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## ORIGINAL ARTICLES.

### TREATMENT OF OLD CASES OF HIP DISEASE.

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On the streets of any of our larger cities one will see many examples of cripples walking with one limb either dangling in the air worse than useless, due to the extreme flexion at the hip with abduction, or else they will be seen walking very imperfectly on a high built-up shoe. It is the treatment of these cases and also that of convalescent hip disease to which I wish to call your attention.

There is no doubt that if convalescent cases of hip disease were carefully and persistently treated during the long period to complete recovery, whatever deformity had existed up to this time, and that which accompanies this period, could be entirely overcome without operation. During the convalescent period, the spasm of muscles having entirely disappeared, traction is not considered necessary—a brace that simply gives protection to the joint in walking is sufficient. This protection from jar in walking is especially required in the first part of the step, *i. e.*, at the time when the heel is brought to the ground.

This can be easily accomplished by using the caliper, the upper part of which is similar to the ordinary hip brace with

stem, pelvic band and perineals, the lower part cylindrical in shape, turned at right angles to the stem and passing through a hollow cylinder in the heel. The stem and perineals should be of such length that the heel of patient, though inside the shoe, should bear no weight, all weight being taken up by perineals.

The brace may be jointed at the knee, and the patient can then get about quite easily and with comfort. In small children the joint is unnecessary, and in clinical patients the question of additional expense debar the joint. Dr. A. B. Judson, of New York, devised a brace for these cases, using one perineal band—he calls it the perineal crutch.

When shall a case of hip disease be considered to have progressed far enough to permit the removal of the extension splint and the substitution of a convalescent brace? The solution of this problem is much a matter of judgment. It is better to allow the extension splint to be worn unnecessarily long than for the substitution to be made too soon. It is essential that one wait until all pain and acute symptoms have been absent for some months, and there exists no muscular spasm. Likewise during the convalescent stage it is better that the protective splint be worn longer than necessary than for too short a period. From one to three years will usually be necessary. The discontinuance of the protective splint should

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be a gradual process, the splint only being removed part of the day or for short walks; but when the patient intends to do considerable walking the splint should be resumed. After some days' or weeks' trial of leaving off the protective splint, should it be found that the joint is becoming painful and sensitive, it is better to return to the constant wearing of the splint for six months or a year longer.

#### OLD HIP CASES WITH DEFORMITY.

The deformities requiring correction are flexion and adduction. These deformities produce an apparent shortening of the limb, or, as it is called, "practical shortening," in contradistinction to real shortening, which latter may be quite small while the former is considerable. Abduction exists as a deformity, but, as it increases the practical length of a limb already actually shortened by disease, the deformity is rather of an advantage than otherwise and does not ordinarily require correcting, unless excessive. In adduction, besides shortening, there is tilting of the pelvis. In order to bring the foot down in the act of walking in those cases where there is fixation at a moderate angle of flexion, motion must take place at the spine, thus producing lordosis; and where the angle of deformity is great, it may be nearly or quite impossible to get the foot down. In these cases a practical lengthening of the leg is obtained by building up the shoe. When the deformity is of such a grade as to seriously interfere with progression, surgery is called upon for relief from the condition.

I have been surprised in several instances of old cases of hip disease with considerable deformity where it appeared that the ankylosis was very firm and bony, that on the application of continuous extension in bed for a few weeks the deformity would be considerably reduced. This had led me to believe that many if not most of these cases should be given a trial of extension in bed for reduction of deformity before proceeding to operative measures, or at least before performing an osteotomy. By the use of adhesive straps to the leg, with weight and pulley, extension can be obtained, and counter-extension secured by the foot of the bed being raised or by the use of the perineals with attachment to head of bed. With considerable adduction it is a good plan to make counter

extension by a perineal to the other hip. After a trial of extension in bed with a failure to reduce deformity, there remains as means of correction: 1. Brisement forcé, with or without myotomy, tenotomy, faciotomy, etc. 2. Osteoclasis. 3. Osteotomy.

Brisement forcé should be limited in use to those cases in which there is evidently only fibrous ankylosis. There is the danger in the use of too much force of fracturing the thigh bone at an unfavorable point; and again there is the danger of relighting the tubercular process. If there is considerable shortening of the flexor or adductor muscles, or of the fascia, subcutaneous division of these structures will greatly aid in rectifying the position of the limb. Frequently the capsule of the joint is found shortened, and, in some cases, an open incision down to the joint (cutting everything which obstructs, including the capsule) is found to be necessary before the limb can be straightened. After the limb is straightened it should be encased in a plaster-of-Paris spica, or fixed by means of extension. Absolute rest is necessary for a variable period; and should there be heat about the joint, giving evidence of some inflammation being produced, bags of ice placed about the hip frequently reduces this activity in a short space of time. After all danger of inflammatory action is past the patient should be fitted with a protection splint and allowed to get about.

Osteoclasis and osteotomy are reserved for those cases in which there exists bony union or a fibrous ankylosis of a very firm character. It is true that osteoclasis is sometimes the result of brisement forcé, but this is accidental and not the desire of the operator. In performing osteoclasis appliances are used to hold the pelvis rigid while force is exerted on the limb sufficient to fracture the bone or break up the ankylosis; but the point of fracture is so uncertain and the operation as a whole lacks precision and is so unscientific that it has been replaced by osteotomy. Osteotomy is by far the most satisfactory operation for the rectification of deformity in a bony ankylosed hip. This operation has been performed at different points near the head of the bone. Adams' operation was a division of the bone at the neck. Sayre and Barwell divided the bone between the greater and lesser trochanters, while Gant

performed osteotomy just below the trochanter minor.

This latter operation, now admitted the best by most surgeons, is based on the anatomical reasoning that the resistance of the psoas and iliacus being set free, a return of the deformity is not to be expected; also that by operating at a lower point than had formerly been done, the operator is more likely to strike healthy bone and less likely to relight the old inflammation.

#### GANT'S OPERATION.

Having determined that all inflammatory action in the joint has ceased and that probably nothing short of an osteotomy will correct the deformity, the night before the operation the thigh is encased in a dressing of soft soap, or soap linament, with proper outside bandages. By the next morning it will be found that the outer layers of epidermis are softened and will readily wash off. Then ether and alcohol may be used to remove any oily or soapy substances remaining. The patient, under an anæsthetic, is placed on his side with a sand bag between the thighs. The trochanter minor having been marked out, the osteotome is introduced at a point just below the level of this trochanter, on the outer aspect of the thigh. The best osteotome for this work is an instrument whose length should be about seven inches, width of cutting-edge three-eighths to one-half inch. It should be tempered to a hardness between that of a cold-chisel and the carpenter's chisel. The handle should be marked every half inch, to show the depth to which the instrument has penetrated. This is more than theoretically indicated, for I have seen the osteotome driven through the thigh and one and one-half inches into the sand bag. In introducing the instrument into the thigh, the edge of the blade is held parallel to the axis and is made to penetrate the skin, fascia, muscles, periosteum, down to the bone; the blade is then turned at right angles to the limb, and, with sharp blows of a mallet, preferably a wooden one, the osteotome is driven through the bone, being loosed and driven at different angles after every two or three blows. When only a shell of bone remains, the instrument is withdrawn and the fracture completed by manual

force. The limb is then brought down to as nearly the horizontal plane as possible, at the same time putting it in a position of abduction. This abduction is to increase the practical length of the limb and is thereby a positive advantage. There is little or no bleeding. The wound in the skin is very small and is covered over by oiled silk or rubber gauze; over this is the antiseptic dressing, and over all is applied a plaster-of-Paris spica reaching from the axilla to the ankle, and it may also include the foot with advantage. The limb is left in the plaster spica from four to six weeks, after which it is removed, the parts examined and measure is taken for a convalescent walking-splint. By the time it is made and applied the limb is strong enough to be used with the aid of the splint. The convalescent splint is worn for three to eight months, or longer.

As a result of these operations we have a practical lengthening of the limb from one to four inches, the limb placed in nearly a line with the body, and in walking the spine is held upright instead of being lordosed, as is required with a flexed limb.

Some time ago I reported in detail the results in sixteen cases following Gant's operation. I give a summary of that report in the table here appended.

(See table on page 4).

From this table we see that the average age of the patient was eleven years, the oldest being sixteen, the youngest five and one-half. We find that the hips were held fixed at an average of  $135^{\circ}$ , i. e., half way between a straight leg and one held at a right angle. By the operation they were brought down on an average of  $36^{\circ}$ , thus bringing the leg to within  $9^{\circ}$  of being perfectly straight ( $171^{\circ}$ ). The average shows a practical shortening of two and a half inches before the operation and only one inch shortening after the operation. There was no motion at the hip in any case before operation, while after operation there was motion at the joint in several cases. All of the cases were improved in their ability to walk—some greatly, others only moderately. There were no untoward symptoms in a single case. We therefore conclude that the operation is a great boon to those having considerable deformity as the result of hip disease.

Case.	Age.	Time Spica Remained On.	Angle of Fixation Before Operation.	Amount Leg was Brought Down.	Greatest Extension After Operation.	Adduction before Operation.	Practical Shortening Before Operation.	Increase in Practical Length.	Practical Shortening After Operation.	Am't of Motion at Hip before Operation.	Amount of Motion at Hip After Operation.	Ability to Walk After Operation.
1	12 yrs.	8 weeks.	125 deg.	40 deg.	165 deg.	.....	4 inches.	2½ inches.	1½ inches.	None.	Small angle.	Walking well.
2	13 "	4 "	135 "	.....	.....	Considerable.	8 "	6 "	2 "	None.	.....	Limb strong.
3	14 "	.....	155 "	.....	.....	Adducted.	2 "	2 "	None.	None.	Small amount	Wearing brace.
4	6 "	4 "	150 "	20 "	170 "	.....	1 "	½ "	½ inch.	None.	.....	" "
5	8 "	5 "	145 "	25 "	170 "	.....	1½ "	½ "	1½ "	None.	Slight motion	" "
6	9 "	4 "	130 "	40 "	170 "	.....	1 "	½ "	½ "	None.	" "	.....
7	7 "	4 "	120 "	.....	.....	24 degrees.	3½ "	1½ "	1½ "	None.	.....	Walks well.
8	10 "	4 "	130 "	45 "	165 "	.....	3½ "	1½ "	2 "	None.	Considerable.	" "
9	5½ "	4½ "	130 "	40 "	170 "	.....	½ "	None.	½ "	None.	.....	.....
10	16 "	5 "	.....	.....	.....	.....	4½ "	2½ inches.	2 "	.....	Considerable.	Walking with comfort.
11	15 "	6 "	135 "	.....	.....	.....	.....	None.	None.	None.	.....	Greatly improved.
12	9 "	4 "	135 "	40 "	175 "	.....	4 inches.	1½ inches.	2½ inches.	None.	40 degrees.	Walks well.
13	14 "	4 "	130 "	45 "	175 "	.....	2 "	1 "	1 "	None.	None.	Much improved.
14	6 "	4 "	135 "	41 "	176 "	.....	None.	½ "	½ (larger)	None.	None.	.....
15	15 "	.....	.....	.....	172 "	.....	.....	.....	3½ inch.	None.	None.	Walks well.
16	14 "	5 "	140 "	30 "	170 "	.....	2½ "	1½ "	½ "	None.	None.	" "
Average.	11 yrs.	4wk. 5d.	135 deg.	36 deg.	171 deg.	.....	2½ inches.	1½ inches.	1 inch.	.....	.....	All were improved.
Maximum.	16 "	8 "	155 "	45 "	176 "	.....	8 "	6 "	2 "	.....	40 degrees.	Greatly improved.
Minimum.	5½ "	4 "	120 "	20 "	165 "	.....	0 "	0 "	0 "	.....	0 "	Some moderate improvement.



## COMMUNICATIONS.

## WHAT THE MORTALITY SHOULD BE IN MATERNITY HOSPITALS OR PRIVATE OBSTETRIC PRACTICE.

JOSEPH PRICE, A.M., M. D., PHILADELPHIA.

There is very much skepticism as to the statistics of mortality in maternities and private practice. About one fact there can be no dispute, that is, that there are too many deaths from infection and septic causes. The mortality from these causes both in maternities and in private practice, should be nil. In hospital and private practice there will be occasional unavoidable deaths from chronic kidney disease, consumption, cancer or other incurable disease. The common causes of mortality are avoidable and are wholly absent in the Preston Retreat and other of our maternities. Labor is a perfect natural process when all the conditions are normal and an ideal cleanliness is rigidly observed. Where the conditions are abnormal or there occurs those accidents to parturition prompt and skillful surgery will save life in nearly all cases. Our obstetrics have been aided by our greatly advanced knowledge of the structures of parts, our increased knowledge of puerperal conditions, both normal and pathological. The fevers of the lying-in period have been banished from the lying-in Hospital—formerly rarely free from these and frequent in private practice. The intelligent and conscientious physicians by a more careful watching of cases have made the accidents of maternity less frequent and fewer mothers are hurried to premature death.

Deaths in child-birth are noted more than formerly and the causes inquired into. Happily the mother begins to count for somebody and the causes for her needless sufferings are reckoned. There are no cases more dependent upon the care and ability of others than that of the mother and her new-born infant. There is no responsibility more vital than that of those attendant upon them. They should have skill and knowledge of their duty in all its manifold relations. The responsibility in such cases is too often treated lightly. It would be startling to know, with all our boasted advances, how many

mothers and infants are sacrificed to ignorance. The awkward, slovenly and unskillful obstetrician, bad hygienic environments and ignorant nursing—these have the most to do with the mortality in these cases. It is the skilled experience of the physician, careful, intelligent, and trained nursing, the cleanliness and better sanitary conditions that give to maternities their advantage. Make external conditions healthy, and there will be few or no deaths in maternity cases from septic causes. The advantages of the Preston Retreat, the Sloan, and maternities of modern build, lies in their construction with scrupulous regard to the best hygienic arrangement, in the use of appliances which have stood the severest tests of sanitary science, where the patients are isolated, far removed from the channels of septic infection. With the advance of general intelligence there is a better recognition of the vital importance of the best hygienic conditions, and stronger and louder grows the demand that, in the service of these institutions, to the bedside of mothers shall be called only those of skill, and the knowledge which comes of long and patient study and wide experience. The fact is coming out into strong light that two lives are involved. Men pass out of our colleges to active maternity work without ever having attended a maternity case. The time is not distant in the future when the directors of maternity hospitals will not dare to appoint a man to *direct* or have *official charge* of such *vital interests* without a rich, practical experience and sound judgment. They will be held responsible for the success of their trust, and it is to be hoped will be held *criminally* responsible for the choice of a person to such trust with no more pride of personal cleanliness and cleanliness of environments than a stable boy, dirty in all the term implies—morally and personally. The physician who stands at the bedside of the mother should have knowledge of

his work in all its details, should be ready, quick and full of resource, and have morals upon which the most penetrating search light can be turned.

The Preston Retreat had thirteen hundred and thirteen consecutive cases without a death from any cause. Fourteen hundred cases with one death from mania. The Board of Directors and friends of the institution may well feel proud of this Record when it is contrasted with the good records of the best maternities of Europe. At the Imperial Lying-in Hospital at Vienna the death rate from 1881-7 was 7 per 1,000. At the Paris maternity, from 1882-7 the average had been 11 per 1,000. At one of the chief materanties in England 6 in 1,000 and throughout England and Wales was 1 in 200.

But the mortality in child-birth does not represent all the mischief. By ignorance and want of skill many women are rendered sufferers for life, useless to their families, friends and society. There are advantages in favor of the mothers in rural sections over those of the dense populations of the cities—they have plenty of fresh air, healthy and moderate food and with them there is less *ignorant and vulgar tight rope lacing*.

The Retreat has never refused admission to married women. In its practice it has kept strictly within the restrictions of the endowment through the charity of which it was founded and by which it is maintained. There has never been any attempt at that species of legerdemain which characterizes the management of some institutions to divert the charity of the institutions into other channels than those intended by the founder. The affairs of the institution in all their details receive the attention of the Directors who are cultured, honorable men from the body of the community, representative of varied business interests and many of them actively identified with other important charities.

Hundreds of unmarried women have applied for admission, who under the requirements of the endowment had to be refused and referred to other institutions. Both from professional and humanitarian motives. I should have been glad to have admitted these greatly-wronged and unfortunate women, but neither the directors nor I had any election in the matter. From a health-stand-

point these unmarried women were greatly preferable, as patients, to very many of the married ones admitted. Many of the married ones coming within the charity were poor, wretched, badly-fed and meagrely clothed. Many of them coming out of dense communities, narrow impoverished environments, a poisoned atmosphere, had been neglected and beaten by drunken and beastly husbands, so that they possessed but little stamina, mental, moral or physical with which to encounter the perils and endure the sufferings of maternity.

The Preston Retreat is the only maternity where patients are cared for the same length of time, six weeks, thus adding four weeks to the time of other maternities, and further adding to the time within which death might occur from puerperal or other causes, and thus increasing the statistics of the mortality of the institution. We feel that we are not claiming too much, when we say that the Retreat under the policy of its Directorship has exerted a wide, extending and greatly beneficial educational influence. It has been visited by physicians of every civilized foreign country, and by many eminent representative physicians of every state of the American Union. The object and motive of these physicians was to study the plan of building, sanitary arrangements, and methods of management, and the verdict of all has been gratifying. There is yet another educational feature associated with its management one that cannot be otherwise than far reaching in happy results, that is the thoroughness with which nurses are trained for their responsible duties. The trained nurse is fast becoming as important a personage in the lying-in chamber as the physician. The demand is for cleanliness, intelligence, the very best and most thorough training in all the many qualities essential to the successful nurse.

#### Treatment of Pleurisy.

**R** Guaiacol pure..... 3j.  
Tincture of Iodine..... 5viij.

Paint the whole of this liquid each evening on the affected side. The temperature quickly falls, an abundant perspiration takes place, and the effusion becomes soon absorbed.—*Med. Press and Circular*.

## SYMPOSIUM ON EXTRA-UTERINE PREGNANCY.

TRANSLATED BY M. B. WERNER, M. D., PHILADELPHIA.

SUTUGIN gives his views on the subject of abdominal pregnancy, which correspond largely with those of Macteck, R. Teuffel, Bandl, and reporting 2 cases which came under his own observation. Patient aged 33; second pregnancy; 4th month, fell from a street car; general peritonitis; patient was 2½ months in bed. The following January, 1890, a cystic tumor of irregular form could be felt in the abdomen, reaching three fingers above the umbilicus. The small parts of the living fetus could be readily felt. In order to relieve the patient, Sutugin made an opening in Douglass' cul-de-sac, which was followed by a large quantity of blood; the opening was tamponed with iodoformized marly. The heart's action being weak, it became necessary to desist from further operation; the patient died two hours after.

*Autopsy.*—Behind and somewhat above the enlarged uterus was found the sac containing the fetus. The placenta was found attached to the posterior wall of the uterus, the right broad ligament and the deepest portion of the Douglass' cul-de-sac extending 9 cm. along the rectum. Attached to the fundus of the uterus was found a pediculated fibro-myoma. The anatomical diagnosis was as follows: *Nephritis Parenchymatosa, Hemorrhagic Acuta, Hydro-Nephrosis, Cystitis Catarrhalis, Endometritis, Graviditas Extra Uterine Abdominalis.* Sutugin sums up in the following manner: Retro-uterine abdominal pregnancy is usually interrupted early by the formation of hematocoele; in very rare cases the gestation may go on to term. The early stages of abdominal pregnancies always have their beginning in the uterus. The symptoms of compression of the intestines and uterus appear earlier than in the other forms of ectopic gestation. Aside from the usual uncertain symptoms of pregnancy, examination will disclose a compressible swelling located behind the uterus, that organ itself being enlarged and displaced anteriorly. In the second half of pregnancy there will be found a round, irregular cystic tumor in the abdomen, in which may be felt the small parts of a fetus. Of importance diagnostically

is the diminution of the vaginal canal, produced by the mass felt posteriorly giving to the examining finger a sensation of placental tissue. The cervix is usually high and sometimes out of reach. Therapeutically, Sutugin concludes, that when rupture of the sac takes place with hemorrhage, an early opening in the posterior vault of the vagina, laparotomy with complete removal of placenta is indicated.

2. MANDELSTAM reports the following case. Patient aged 24; had previously given birth to one child; not pregnant for 4 years; had been treated during that time for uterine disease. Last menstrual period occurred in the latter part of March, 1891. First of May, collapse, expulsion of the decidua membrane. A tumor could be felt to the right of the uterus. This increased up to the middle of July, to the size of about two fists and was adherent December 31st. There was found a round tumor in the middle of the abdomen, extending 2 fingers above the umbilicus. This was strongly attached to the uterus. In the early part of that month, motion had been felt by the patient. Early part of February there was considerable pain, accompanied by fever 39.5° C.; laparotomy performed February 9th; removal of the dead fetus with its ovisac; it was 39 cm. in length. The free portion of the tumor, after being thoroughly ligated, was removed; recovery complicated by pneumonia. Mandelstam further reports the histories of 11 cases, which have come under his notice during the last eight years. He advises the expectative method of treatment, even if rupture has taken place. Quoting his own words, he states, "that in the majority of cases with absolute rest, strict diet, the use of ice and opium in large doses, hemorrhage can be controlled."—Ed(?)

3. MAUERHOFER reports the histories of 4 cases operated upon for ectopic gestation, observed by him in the Frauenklinik, at Berlin since 1878. He advises operative procedures in the first half of pregnancy, performed under aseptic precautions with the aid, if necessary, of tamponing the pelvic cavity. He regards this treatment as the safest even in the most unfavorable cases. Injections of

morphine in the ovisac or the application of electricity is neither used nor advised.

In the second half of pregnancy, if the fetus is living, the latter should receive some consideration so long as it does not interfere with the actual health of the mother. The time for abdominal section being left to the judgment of the physician. If the fetus is dead it is necessary to await the obliteration of the placental circulation, provided sepsis or internal hemorrhage does not make it imperative to perform an entire section.

The tamponade of the small pelvis is considered by him a great advance, since many cases in which it becomes impossible to remove all the placental attachment, one has the seat of such regions at their command for constant attention.

4. MURET describes three cases of tubal pregnancy in the early months, observed by him at the Strassberger Frauenklinik.

CASE I. Tubal pregnancy of the right side, rupture at the end of the first month, hematocele, carcinoma of the portio-vaginalis. Total extirpation of the uterus, with its adnexa and the hematocele on right side.

CASE II. Tubal pregnancy of left side, rupture of the tube in the sixth week, hematocele, salpingectomy and enucleation of the hematocele.

CASE III. Tubal pregnancy of right side, rupture at the end of second month; tubal mole, hematocele and salpingectomy.

Muret concludes his remarks as follows:

It is important to decide between the complete or partial rupture and expulsion from the tube. A partial escape of the product of conception may result in the tubal mole; the complete escape usually results in the formation of hematocele, which usually ends in the various known complications. In cases of complete tubal abortion, the symptoms of acute internal hemorrhage are less than in the cases of ruptured tube, although some cases have been known to show symptoms of profound shock.

In cases of incomplete protracted abortion, the hemorrhage and destruction of the ovum, frequently leads to the formation of a mole. The hemorrhage, which has taken place into the tube will find its way through the open end of its fimbriated extremity, and thus lead to

the formation of a hematocele. As long as the degenerated ovum, or a portion of it, remains in the tube, it predisposes to occasional hemorrhages, in precisely the same manner as in a protracted uterine abortion.

The tubal walls are frequently found quite thin at the place of attachment of the mole and the degenerated ovum, even though the ostium abdominalis is patulous. This thinning is explained by a local distension of the wall in consequence of the hemorrhage. These cases have but one method of treatment, which solves itself down to the removal of the tube. This can only be done through the abdomen, and should never be attempted through the vagina.

5. GRAEFE. Multipara, 37 years. Diagnosis first made was of a pregnant retroflexed uterus of two months, with beginning abortion accompanied by pelvic peritonitis. Later a cystic tumor was found in Douglass' pouch, not connected with the cervix; there was discharge of decidual shreds. This led to a change in the diagnosis to extra-uterine pregnancy of two months. There was sudden collapse of the patient without previous warning. A large retro-uterine hematocele could be felt, no doubt originating from the hemorrhage produced by the rupture of the tube. On the following day, laparotomy, ligation and removal of the tube. Owing to a continuous bleeding in Douglass' pouch, a tampon of iodoform gauze was placed, the end of which was allowed to pass out through the abdominal wall. Drainage soon ceased, and there resulted a collection of pus in the space posterior to the uterus, which evacuated itself through the lower angle of the abdominal wound. A longer drain was inserted, and later, drainage was made through the vagina. The patient made a good recovery.

Graefe concludes that the formation of hematocele following a rupture from an extra-uterine pregnancy, during the early months of gestation, will in no wise insure against the possibility of another hemorrhage into the abdominal cavity, and though even this should not be the case, it usually takes a long time for the absorption of a hematocele, the patient being a sufferer throughout this period, not alone from the presence of the hematocele, but from the pre-existing diseased appendages.



Bearing all this in mind a radical operative interference seems not only the most justifiable, but also the most promising to the patient.

6. DOBBERT reports various anatomical investigations. He has studied numerous specimens and concludes that in cases where an abdominal section becomes necessary, the method of Dombrowski is the best. Dombrowski reports 5 cases in the year 1892, treated in this manner for retro-uterine hematocoele; 3 out of 5 were directly traceable to tubal disease. Dombrowski's method is as follows: An incision is made into Douglass' pouch through the vagina, which is extended up to the sac of the hematocoele; the vagina is tamponed with iodoform gauze. The patient is then placed in the Trendelenberg position, an incision made in the abdominal wall through the linea alba. If the tumor is not adherent to the parietal peritoneum, it is drawn up and the sac attached to the abdominal opening by means of sutures. The contents are then removed, and the sac cleansed; the vaginal tampon is now removed; by means of forceps, a long drain of a gauze is passed through the abdominal wound down to Douglass' pouch and out through the vagina. An additional tampon is placed in the floor of the cul-de-sac. Closure of the abdominal wound down to the tampons. Tampons are removed as often as necessary, their length being guided by the size of the opening; the vaginal drainage lasts the longest.

7. HERZFELD reports eight tubal pregnancies occurring during three months at Schauta's clinic. All cases were operated on by abdominal section with but one death, due to suppurative peritonitis. The etiology of extra-uterine pregnancy was traced in all cases to chronic and inflammatory changes of the uterus and its appendages, primarily due to gonorrhœa or previous puerperal inflammation. Four were traced directly to gonorrhœa, and two to previous pelvic inflammation following labor. Among the eight, two were primipara, one was infected by gonorrhœa, the other complicated by large fibroma. In the six remaining cases the interim between the last conception and the present was respectively fourteen, eleven, ten, nine, seven and five years. This was of especial interest, since the possibility of conception was present in each case. In two cases

the period of pregnancy was completed; in one the operation was performed eleven months after supposed conception; in the remaining cases the period of pregnancy ranged between six and eleven weeks. It is of importance regarding diagnosis to bear in mind the difference in the growth of the uterus between ectopic and normal gestation—the uterus developing more in length than width in the ectopic variety. The question, however, becomes more difficult between the extra-uterine and the pregnancy in the uterus unicornus. The author, however, calls attention to the position of the ligamentum uteriteres, as an aid in differential diagnosis.

HERZFELD closes his remarks by giving a careful description of Schauta's method of operation done under strictly aseptic conditions. While it is always desirable to remove the entire ovisac, it often becomes a dangerous proceeding. In the latter case he usually desists in performing a radical operation, uniting the sac to the lower angle of the wound, and drains. Two such cases are reported, in both the fetus was dead.

8. ZEDEL has presented four specimens of tubal pregnancy, having made a careful histological and microscopical study of each. The ovum was imbedded in the tube. The epithelium in the ovisac was flattened, due, in all probability, to pressure. Generally, there is no complete decidual change in the tubal mucous membrane, only a portion being found near the insertion of the ovum. A complete development of the decidua vera being rarely met with. The upper layer of the serotina can be traced to the lower layer of the ciliated epithelium. The decidua tubaria originates principally from the perivascular connective tissue found in the mucous membrane. The author has been able to demonstrate the connection between the arteries and veins and the intervillous space in a tubal pregnancy of fifth week. The loss of the connective tissue and muscular layers and the incident changes following the cell proliferation of the intima, materially favor the increase of blood supply. This latter is, to his mind, the cause of breaking down the serotina and establishing the communication between the lumen of the blood vessels and the placenta.

The author arrives at the following conclusion: that in the beginning of the

fifth week, the intervillous circulation establishes itself, and fetal life is nourished by the maternal blood. The other points in the circulation are the same in tubal as in intra-uterine pregnancy. A decidua reflexa forms in the tube, and is for the development of the ovum until the intervillous circulation has been thoroughly established. Fibrous layer originates not

only from the upper layers of the decidua materna, but also from the neighboring structures, the cellular layer of Langhans. The placenta consists of the original villous chorion, and the superficial layer of the decidua. The development of the ovum proceeds in the same manner as in the uterus.—*Schmidt's Jahrb.*, No. 9, 1893.

## DYSMENORRHOEA—ITS CAUSES, SYMPTOMS AND EARLY TREATMENT.

M. F. DEHART, M. D. JERSEY CITY, N. J.

In these days when preventive medicine is the favorite theme of all the most scientific physicians, when such thorough investigations are being made into the causes of disease, and all agree that it is so much easier and better to avoid sickness than to effect the most brilliant cures, it seems strange that so little is said on this subject, which is the cause of so much suffering and the first symptom of so many serious life-long diseases which require at last, the entire removal of the uterus, tubes and ovaries to allay pain and restore peace, which unfortunately, even then the patient does not always find until she folds her hands in death.

One reason for this undoubtedly is that women bear this oft-recurring pain without complaint for many years, as they have been taught to look on this as one of the misfortunes of their sex and inevitable. Their mothers, often having had the same trouble, do not look on it as anything alarming, and so content themselves with giving hot drinks, ginger tea or gin, until the pain has worn itself out for that time, but only to return with increasing intensity at the next menstrual period. This from being an occasional occurrence soon becomes a fixed habit, and is looked forward to with dread from month to month.

As it has been so gradual in its progress, no one realizes how strong a hold it has taken, or how much it has undermined the general health, causing nervousness, dyspepsia, and a long train of mental symptoms, which are as much a part of the disease as the pain. Women hesitate for a long time before consulting a physician, fearing that an examination will be

necessary or an operation suggested. Some complain that physicians are indifferent to these early symptoms, and make light of this pain, assuring them that it is nothing serious; that all women are the same, and that they ought to marry, which will, no doubt, cure them; or content themselves and pacify the patient with a prescription of morphine, to be used when required; that others, going to the other extreme, advise an operation for every case without trying the effect of medicines, or suggesting hygienic measures, which might in the early stages be sufficient for a cure.

In this way the years run on until this once slight functional disturbance has drawn everything into the tangle, and every organ sympathizes, adding its quota to the general misery, so that it is difficult to tell what is cause and what effect, or to know where to begin to unravel the snarl and restore harmony to the disturbed economy.

Listening to the long array of symptoms, and noticing this gradual advance and steadily increasing intensity from month to month, and from year to year, one is forced to ask, "Why did you not come long ago," and "Was there no one with common sense enough to tell you that menstrual pain was *never* natural, but on the contrary, like all other, always a signal of distress," "To notify you that something was wrong, that it was not enough to stupify one's self with anodynes before learning the truth it was sent to announce, and that enduring it with patience was no virtue until an energetic effort had been made to find out the cause and remove it, after which there would doubtless be ample

opportunity to develop this admirable Christian grace."

Among the causes which bring about this unfortunate condition we shall find everything that tends to lower the general health,—indoor life with too little light, air and sun, too little general exercise, and too much persistent use of a few muscles, as in dancing, sewing on a machine, or long standing in stores—too little legitimate occupation for the mind and too much stimulation and excitement of any unhealthy kind causing loss of sleep—imprudent exposure to cold at any time and especially during the menses—irregularities and improprieties of diet causing constipation and general disturbances—senseless and absurd clothing, which is too heavy and too tight about the waist and not evenly covering the body, leaving many parts too much exposed and others overburdened—long unyielding corsets which interfere with free natural movements of the body, pressing the abdominal organs downward and holding the uterus in a cramped and uncomfortable position.

At first the pain is only for an hour or two, either before the menses appear or just after, but if unrelieved, it becomes more severe and lasts longer each month until the premonitory pains occupy the whole week previous to menstruation and the following week is required to recover from its effects, thus three weeks out of the month are given up to this function which should be painless, and no more disturbing than digestion or respiration. This condition prevents exercise, interferes with all work, study and amusements, leaving its victim a chronic invalid shattered in mind and body, of no use to herself and a burden to others. Is it any wonder that she is a prey to whims and fancies—that she aggravates her real sufferings by many that are purely imaginary, thus wearing out the patience of friends and wasting her own life?

It seems scarcely reasonable to suppose that all this trouble can be cured by any one operation however radical, for her whole nature is involved, and she is a wreck physically, mentally and sometimes morally—her will-power is destroyed, and there seems to be no place to begin the work of cure, for medical science is, as yet, often powerless to avert the penalty attached to violated natural laws.

In view of these facts, and I think that any one who has had much experience

with these cases will admit that they are not overdrawn, is it not the part of wisdom to instruct women on this all-important subject, not waiting until irremediable evils have rendered advice and treatment well-nigh useless? Would not a wise preventive treatment be followed by as good results here as in typhoid fever or septicæmia, and can physicians feel that they have done their duty to the families under their care if they have not endeavored to educate them on this subject as well as on other truths of hygiene?

In the early days, a thorough change of habits with careful regulations of the bowels, and *Assafœtida* gr. iv, three times a day for three days before the expected period, and *Assafœtida* gr. viij, xii, three or four times during the first day, will often give speedy relief, and if continued for several months will many times effect a permanent cure.

This simple prescription for so formidable an array of symptoms, may seem to many as absurdly inadequate as the old-time advice given to the leper by the prophet to wash in the river Jordan—but simplicity is said to be the height of art, and success is a sufficient answer to all objections.

#### A Prolonged Fast.

There is reported from Russia a case of unusually long fasting. A young girl of seventeen was overtaken by night near the village of Ruzino in Moscow on the 24th of last November. She took refuge under a small outbuilding covered with straw. During the night it snowed violently, and in the morning the girl was unable to force her way from under the snow. The first day she ate five bits of bread she had with her, after which she had no food but the snow. Fifty-one days later she was discovered buried under three feet and a half of snow. On being taken to the hospital on January 14th, she was in a state of extreme exhaustion and unable to move a limb, though entirely conscious. There was a general cutaneous anasarca. The mucous membranes were excessively pale, and there was no trace of *panniculus adiposus*. The muscles were much atrophied. The respiration was 26; the pulse 84, small and feeble; the temperature 38° C. For the next two days she remained semi-conscious and somnolent, but rapidly recovered, and at the end of a week was able to take hospital diet.—*Ex.*

## SOME POINTS OF INTEREST TO THE MEDICAL PROFESSION.\*

SENECA D. POWELL, M. D., NEW YORK.

In accepting the Presidency of the Medical Society of the County of New York, with the duty and responsibility of presiding over the deliberations of a body so justly renowned and influential, I cannot but be sensible of the honor bestowed and the confidence expressed by your selection. You have my thanks; and I hope that I may be able so carefully and impartially to discharge the duties of the office that your confidence will be justified.

I yield to no one in appreciation of the dignity of this organization, and the importance of its influence. It is the ancient and legally recognized authority upon professional standing and medical ethics. The size and character of its membership, with its location in this cosmopolitan city, make it a power in our profession, perhaps, unequalled by any like association in this country. Its spirit is contagious. Its deliverances are esteemed as professional oracles. Its efforts towards any object carry the prestige, power and effectiveness, which naturally pertain to a body of men distinguished for the highest professional knowledge and success.

Such being the case, a certain leadership belongs to this Society, which cannot be refused. It is expected—in a sense demanded of us. The position is ours, and its responsibilities cannot be properly ignored; nor can the duties of such leadership be safely neglected. It belongs to this Society to take the initiative in the correction of abuses where discovered, and in the introduction of real improvements.

## MORAL EQUITY AS BETWEEN PROFESSIONAL BRETHREN.

To this end you will permit a question or two, not inappropriate to the occasion, and which I heartily commend to your good judgment and enlightened professional conscience. My first point is not so much a question of legal justice, but rather a matter of moral equity as between professional brethren, and especially as between two classes with unequal opportunities and rewards. Of course it belongs

to us to lead the medical profession in the adoption of all measures calculated to secure to every member full legal rights; but quite beyond this, I think it will be conceded, that upon the more favored and successful practitioner rests a special moral obligation to see that no procedure of his works an injustice, or is occasion of needless embarrassment to his less fortunate brethren. I am satisfied that such injustice and embarrassment is occasioned by the readiness of the communities to abuse opportunities for free treatments, together with the indifference of many physicians, and their failure to investigate and to discriminate in such cases. It is not my thought to check a real benevolence. I would be the last man to deny the reliefs and benefits of science to the poor. It is a glory of this city, that no one, in whatever extremity of poverty, needs to perish or suffer for lack of prompt and skilful medical attention. But the policy, or at least the practice, of many dispensaries and hospital associations, puts a premium on meanness; and withdraws from the local practitioner his natural clientele, by compliantly serving at the free dispensary those who are abundantly able to pay for what they receive. Not only so, but to appease an uneasy conscience, a nominal fee is asked and given, and further moral obligations are lost to view. This is in fact abetting fraud. It is an outrage upon public confidence, as well as a very palpable injury to a large class of practitioners. Our leading physicians and surgeons connected with these charitable institutions are more or less responsible for this state of things. We freely admit that the case presents some difficulties, but surely new rules, or more conscience, care and discrimination are demanded. A most public and flagrant instance is furnished by the Board of Health in its recent crusades of wholesale vaccination. There is, perhaps, little to be said of the work in Cherry street and the like; but when it comes to the free vaccination of the employes of prosperous business houses and rich corporations, and even of the sleek moneyed men of the Produce, the solidated, and the Stock Exchanges, and

\* Inaugural address before the Medical Society of the County of New York, by the President.



the Board of Trade, the preposterous extent of the abuse and the consequent professional injury in seen at a glance. Such things could not occur did not physicians lend themselves to the scheme. I should prefer to believe it was done thoughtlessly; and I trust that a declaration on the subject by this Society would do much toward correcting such abuses.

Again, whenever a man puts a low estimate on the importance and value of his own service, he so far lowers the medical standard, and thereby injures his professional brethren. Why reputable physicians should consent to serve rich corporations for nominal returns, would seem hard to explain. But the anomaly exists. Many illustrative instances of these misplaced favors will occur to the minds of these present. In this regard the legal profession sets us a different example, and one worthy of our emulation. So far from belittling the importance of his own service to the injury of his own profession, the corporation lawyer exacts the highest fees, and those commensurate with the interests involved. Why should the physician adopt an opposite course?

#### ON EXPERT MEDICAL TESTIMONY.

Another point to which I would call your attention is the matter of expert medical testimony in the courts. Comparatively recent events in connection with some trials of peculiar public interest have given this subject especial prominence. My impression is that the result has been to discredit the value of the expert testimony as a whole. It is evident that in the case of conflict or apparent discrepancies between the testimonies of reputed experts, neither the public, the ordinary jury, nor indeed the bench of judges, nor the bar, have the especial training which would qualify them to discriminate between true and false, and duly to estimate the scientific value and the proper influence of the facts in a given case. The result is to create an impression of vagueness, a natural distrust of the whole business, and of the medical science with which it is associated. Such a matter at first thought might seem beyond the power, if not the province of this Society. But permit me to suggest that it is not really so. Both in the interest of civil justice, and of our profession, the evil might be rec-

tified by the appointment from this Society of a commission or jury of competent physicians to review and to pronounce upon the entire expert testimony in each given case. The summing up by such a commission would in the highest degree inspire confidence and subserve the ends of justice. Of course such a procedure must be authorized by Statute law. But it is entirely within the province of this most influential body to propose and to secure the appropriate legislation.

#### ON MEDICAL LEGISLATION.

And this brings me to another very important consideration affecting our relation to the profession at large, the State and the community. It is an undeniable principle that with a responsibility of any sort must go the power and supervision in the matter under consideration. Now since this is the legally instituted and recognized medical society of the County of New York, and the body in which inheres the major responsibility for whatever action may be taken affecting medical affairs, it follows that all legislation relating to the practice of medicine, either as between physicians, or between the physician and the community, should be first admitted to this Society and receive its approval or disapproval before it is transmitted to the State Society or proposed for enactment as a law. A Society of such a character as this is often asked to endorse plans and schemes which may be worthy of its endorsement, or possibly should not receive its sanction. In my judgment *all* such propositions should be referred to the *Comita Minora* for careful consideration before any official action is taken, and I so recommend.

In view of all that has been said upon this subject and of the necessities of the case, the propriety must be manifest to everyone of adding to our standing Committees one on Legislation, to the especial care of which may be committed all such matters, often among the most important upon which we may be called to take action.

#### A CASE OF OFFICIAL DISCOURTESY.

A recent case of official discourtesy and injustice I think worthy of mention in this place, not so much on account of its intrinsic character, as in view of what appears to me a want of proper *esprit de*

corps and professional sympathy in the treatment of the affair by some of our physicians: Referring to the case of the New York Infant Asylum, it is noted in the issue of the *Medical Record* of November 25th that, "A recent attempt to bring before the medical profession the question of the treatment of Medical Boards by the managers of hospitals, provoked unfortunately, a somewhat sharp discussion at the Academy, and showed again how quickly a number of physicians will side with the higher and the moneyed powers and against their medical brethren."

The facts of the case entirely justify the remark, which I have quoted from the *Journal*. It is indeed an unfortunate state of affairs, not that the atmosphere of the Academy should be stirred by a sharp discussion, but that physicians should be so short-sighted, not to say partial and unjust, as to range themselves upon the wrong side of such a controversy. By all accounts the course of the Board of Managers was arbitrary, ungrateful and discourteous in the extreme to the Board of Physicians, who had long given the institution without reward, and as it now appears without thanks, a valuable service in the frequent rendering of their professional care, and by their advice as to competent men for visiting physicians. Upon what ground such discourtesy to such men can be justified it is hard to see. But my especial point is, that, is if we do not sustain honorable brethren of our own profession in their expectation of just and courteous treatment, we injure and degrade the profession itself. A certain jealousy for professional rights and honor is certainly due from every member of the fraternity; and every failure in this regard not only reacts upon ourselves, but is an injury to all.

#### SECTARIAN DESIGNATION.

Perhaps a mere allusion may not be out of place to the attitude of some, who are not unwilling, to say the least, that an impression should go abroad that they are practitioners of sectarian medicine. If a word to the wise is sufficient, it should only be necessary to recall the positive attitude of our Society upon this subject, and its unmistakable declarations. Article XVII of our Constitution reads: "No member of this Society shall assume any sectarian designation indicating that his practice is based on any special doctrine

or dogma, or specified method of treatment." And again, the closing sentence in the form of application for membership reads: "And (I) hereby declare my abnegation of sectarian principles and practice." The moderate and conservative thought is, that the County Society means just what it so emphatically proclaims, and that the only proper and just course is to receive gentlemen as members, when all the requirements for membership are complied with.

#### ON INCREASE OF MEMBERSHIP.

In closing let me express some sense of the pleasure and profit personally derived from my connection with this Society in the past, and my desire for its present and future importance and usefulness. To this end I ask that the present members have in mind the thought of increasing our membership by the introduction of proper candidates; and that from the older members especial consideration be shown for the young men of the profession, both within and without the Society. Such encouragement is often of great value to the recipients, and the young blood is essential to the health and growth of the organization.

I further crave your consideration and assistance in my efforts to facilitate the business and to promote the interests of this body in the honorable and responsible position in which you have placed me.

#### Purpura of the Newborn.

Glenn (*Transactions of the Royal Academy of Medicine*) reports the case of a first child of healthy parents; no history of syphilis, child asphyxiated when born. At birth the infant was covered with discrete hemorrhagic spots, especially on the face, chest, and back. On auscultation a loud bruit was heard over tricuspid area. The child lived thirty-six hours. On post-mortem the spleen was found much enlarged and of a deep red color, weighing forty-five grammes. Liver enlarged, deeply stained with bile and firm to the touch. Kidneys, with the exception of a few superficial hemorrhages, were normal. Stomach and intestines were covered with purpuric spots similar to those on the skin. Both visceral and parietal layers of the pleura were studded with hemorrhages, the same condition being found in the pericardium. Foramen ovale open. All the remaining internal organs were hemorrhagic.—Ex.

## EXCISION IN THE TREATMENT OF SPINA BIFIDA.\*

JOHN B. ROBERTS, A. M., M. D., PHILADELPHIA.

The unsatisfactory results which are believed to follow operative treatment of spina bifida have induced the profession to largely refrain from active measures in the management of the condition. A most conservative view is found in *Stephen Smith's Operative Surgery*, which the author attributes to Holmes, but seems to fully endorse. He says: "No case of spina bifida ought ever to be subjected to any active operative interference, except in the most urgent circumstances, and the mildest measure which affords any rational prospect of cure should be the one selected."<sup>1</sup>

The Committee of the London Clinical Society, consisting of Messrs. Howard Marsh, A. Pearce Gould, H. H. Clutton, and Robert William Parker reported in 1885 "That the evidence was conclusive that a large proportion of specimens of spina bifida the spinal cord is within the sac;" and that the committee was not acquainted with any means by which it was possible to determine in the living subject that the spinal cord was not in the sac. For this reason the committee believed "that any operation involving interference or removal of the *median vertical portion* of the tumor should be entirely abandoned." This statement was made notwithstanding the fact that the members of the committee were "quite conscious of the large measure of success that has attended the operations of ligature and excision, but we cannot lose sight of the fact that these operations always expose the patient to the grave dangers attending removal of the expanded spinal cord and attached nerves." After an extended examination of specimens and of the literature of the subject, this committee came to the conclusion that the plan of treatment by injection with iodine, iodide of potassium and glycerin, recommended by Morton, was the best with which its members were acquainted, and was the only one which they felt justified in recommending.<sup>2</sup>

Cabot at a recent meeting of the American Surgical Association states<sup>3</sup> that

Treves is of the opinion that operative treatment of bifid spine "can only be undertaken in those comparatively infrequent cases where the sac is quite free from either the cord or any of the spinal nerves," and that "if the sac contains cord elements, result will prove fatal." J. William White wrote, in 1891, that he believed that most surgeons agreed with the opinion that injection with the iodo-glycerin solution is the best method of treatment.<sup>4</sup>

It is not surprising that such expressions as those should have deterred surgeons from attempting excision in spina bifida. It is because I find myself obliged to dissent from these opinions that I recently operated upon a case which I desire to record. A consideration of the circumstances surrounding the fatal issue of my own case and the study of surgical literature have pretty thoroughly convinced me that in properly selected cases excision is not only justifiable, but will be found satisfactory in relieving the patient from the disability due to the congenital defect.

The importance of undertaking active treatment in bifid spine is shown by the record of 647 deaths from this congenital condition in England in the year 1882. Of these deaths 615 occurred while the patients were under one year of age.<sup>5</sup> The fatality of the affection is well illustrated by this record, and is a piece of evidence whose value is not broken by the 13 cases of spontaneous cure found by the London Clinical Society Committee after a laborious search in surgical literature.

Occasionally patients with spina bifida may reach adult life, as in the unusual patient mentioned by Callender, who had attained the age of seventy-four years.<sup>6</sup> The Clinical Society Committee found 13 cases, who were living at, or who had, before death, attained ages varying from nine to forty-three years. Mr. Clutton operated successfully by excision on a lady aged twenty-four years.<sup>7</sup>

<sup>4</sup> Trans. American Surgical Association, vol. ix, 1891, p. 133.

<sup>5</sup> Trans. London Clinical Soc., vol. xviii, 1885, p. 339.

<sup>6</sup> Ashhurst's Principles and Practice of Surgery, Ed., 1893, p. 719.

<sup>7</sup> Sajous' Annual of Universal Medical Sciences, 1892, p. A. 50, from London Lancet, October 10, 1891.

\* Read before the Academy of Surgery, 1893.

1 Edition, 1887, p. 360.

2 Trans. vol. xviii, 1885, pp. 383, 385.

3 Annals of Surgery, August, 1892, p. 122.



These unusual instances of longevity, notwithstanding the existence of such a perilous condition, do not invalidate the evidence of the great infantile mortality shown by the statistics in England alone during 1882. From what I have said it would seem that the two methods which the surgeon should contrast are injection by the iodo-glycerin solution and excision. The Clinical Society Committee collected 71 cases treated by this injection; of these 35 had recovered, 27 had died, 4 were relieved, and 5 were unrelieved. Dr. Morton, the advocate of this injecting material, had informed the committee that of 50 cases so treated 41 seemed to have been successful. I presume that some of the cases in the two lists were the same patients. The same committee collected reports of 23 patients treated by excision of the sac, of whom 16 recovered and 7 died. Ashhurst states<sup>9</sup> that the statistics collected by that committee and by Dr. C. A. Powers show that of 86 cases treated by the injection method, 50 were benefitted, and of the 57 cases treated by excision, 40 cures resulted. Dr. Powers' paper is well worth careful reading, and will be found in the *Medical Record*, July 16, 1892.

The injection of the sac seems to me so unscientific, because it is really groping in the dark, that I am impelled to the conclusion that incision, exposing the contents of the sac, followed probably by excision, is the preferable method of dealing with bifid spine. This conclusion is confirmed by the results attained by myself and others in many operations upon the brain and spinal cord. An aseptic wound of these organs, under ordinary circumstances, seems to be comparatively safe. Operative treatment, therefore, of spina bifida under modern methods must be considered in a rather different light from that of five or six years ago. I agree almost perfectly with those who consider excision a satisfactory and proper operation, even though it be undertaken in children but a few weeks or months old. Various modifications have been proposed in the endeavor to remove the tumor and close the fissure in the vertebral canal.

Two cases are reported by the Committee of the Clinical Society in which the skin was dissected from the sac and then sutured in the middle line over the tumor. I do not know of this method of operation being

performed by others than the two operators mentioned in the report. Death occurred in one case, recovery in the other.

Evacuation of the fluid and excision of the sac of the tumor is the method usually meant when excision is mentioned. The dura should be divided and stitched so that the line of suturing does not correspond with the suture line in the skin. This method is especially advocated by Mayo-Robson.<sup>9</sup> Mr. Mayo-Robson in one case inserted a portion of periosteum, taken from a rabbit, over the closed meninges; and carefully sutured it to the periosteum of the laminae on each side of the cleft. No bony formation resulted from this transplantation, though the periosteum taken from the rabbit evidently preserved its vitality. In one of his cases, cure was accomplished even after suppuration had occurred in the sac. The operation consisted in complete removal of the sac with efficient drainage. Of the four cases operated upon by him, three recovered. This operator also suggested bending the neural arches toward the middle line and uniting them with silver wire in the endeavor to make a bony wall to the defective spinal canal.

Osteoplastic operations similar to the method proposed by Mayo-Robson, but not used by him, have been performed successfully by J. Dollinger,<sup>10</sup> of Buda Pest, by Zenenko,<sup>11</sup> of St. Petersburg, and by Rochet.<sup>12</sup> Berger<sup>13</sup> operated successfully on a child seven weeks old, by transplanting a piece of the scapula of a rabbit, and Bobroff,<sup>14</sup> performed an osteoplastic operation, taking a section of bone from the crest of the ilium of the patient to fill the gap in the sacrum.

Rochet states that the structures resembling nerves traversing the sac are not always true nerves and have no physiological function. They can be cut or exercised without special harm being done to the patient. He says that Bellange reports 11 cases in which nerve filaments of various sizes were cut during operations without any paralytic or anæsthetic phenomena resulting. This observation made my other observers is said to be the rule.

9 Trans. London Clinical Soc., xviii, 1885, p. 218.

10. Annals of Surgery, September, 1887, p. 163.

11. Annals of Surgery, September, 1889, p. 223.

12 American Jour. Med. Sciences, October, 1893, p. 477.

13 Am. Jour. Med. Sciences, October, 1893, p. 478.

14 Annals of Surgery, September, 1892, p. 270.



The securing of a vertebral canal by some osteoplastic procedure would seem to be a very desirable addition to the original operation by excision. I do not know how much better the condition of the patient is, however, after such attempts at securing a bony closure of the gap. Theoretically, it would seem desirable, but many cases have been satisfactorily cured by operation, in which removal of the sac and simple suturing of the skin over the gap in the bone were done. The bone to be used for closing the gap may be obtained as in the operations recorded, or, as suggested by Bobroff, from one of the ribs when the bifid spine exists in the dorsal region. De Ruyter, of the University Clinic at Berlin, has made an interesting study of the question of excision in the condition under consideration.<sup>15</sup> He believes that cases of meningocele are usually proper ones for operation, but of meningo-myelocoele, only those are suitable for operation in which the proportion of the essential elements of the cord involved in the cyst wall is small and derived from a point below the sacral plexus. He excludes from operation all cases of this class in which the nerves given off from the spinal cord, lying in the median line, pass to the cyst wall and thence to the inter-vertebral foramina. He also excludes from operation all cases of myelocystocoele because these cysts are usually small, the skin covering them sound, and the patient's condition about as good as it would be after operation. He gives some suggestions for diagnosing these varieties of spina bifida, and considers a puncture or exploratory incision justifiable for diagnostic investigation previous to operation. Of eight cases treated by surgical operation in the Berlin Clinic during the time over which his study extended, five died.

Hildebrand, of Göttingen, at the meeting of the German Surgical Society this year, presented a careful study of 27 cases of bifid spine and showed that the cleft may involve the bone, dura pia, cord and the over-lying soft parts, or only one or two of these structures. He reports 13 cases operated upon in the Göttingen Clinic, of whom 10 were discharged cured. He advocates operation on all varieties of spina

bifida, excluding only those in which there is a marked degree of paralysis.

I have made no attempt to collect cases of bifid spine treated by excision. The operation has probably not been done very often in America. Cabot,<sup>16</sup> of Boston, Hayes,<sup>17</sup> of Rochester, and Hurd<sup>18</sup> have reported cases. I add the clinical record of a case recently operated upon by me which terminated fatally.

A male child, fifteen days old, was seen by me on September 25, 1893, at the request of Dr. Isaac W. Hughes. The child was exceedingly healthy and well formed, except a bifid spine. The prepuce was, however, adherent, though no true phimosis existed. One of the legs showed some lack of power, but their sensation I did not test. The contents of the rectum and bladder were evacuated at ordinary intervals, though according to the statement of the nurse, there was a tendency to dribbling of urine nearly all the time, and some slight leakage from the rectum when the baby strained. It is possible that these were evidence of a want of control of the sphincter due to condition of the spine. The infant nursed well and cried very little, showing its extremely healthy and comfortable condition. The tumor due to the congenital deformity occupied the upper portion of the sacrum. It was hemispherical and measured about an inch and a half vertically and horizontally, and was elevated above the surface of the back about one inch. The central portion consisted of translucent tissue upon which was an ulcerated-looking space toward the lower portion of the tumor. This granular or ulcerated condition was present at the time of birth. The normal skin extended up the tumor on each side to a sufficient extent to leave only about half the surface of the hemispherical swelling of translucent tissue. The mass fluctuated on pressure and seemed to increase little, if any, when the child cried. Under the circumference of the tumor on each side could be felt a hard edge which seemed almost like bone, but which was evidently the margin of the muscles of the back or the posterior border of the iliac bone on each side.

<sup>16</sup> *Annals of Surgery*, August, 1892, p. 121.

<sup>17</sup> *Ashhurst's Principles and Practice of Surgery*, Ed. of 1893 p. 720.

<sup>18</sup> *Therapeutic Gazette*, October 1, 1889.

<sup>15</sup> *Annals of Surgery*, September, 1890, p. 296.

The parents of the child were given an unfavorable prognosis and an operation by excision advised. Accordingly, I cut away the mass on Wednesday, September 27, 1893. Corrosive sublimate solution was used for the sponges and for sterilizing the surface of the child, but the instruments were kept in betanaphthol solution after having been sterilized by heat. Ether was used as the anæsthetic.

A puncture was made on the right side of the tumor above the margin of the skin, and about two drachms of colorless fluid allowed to escape. No symptoms occurred during this evacuation of cerebro-spinal fluid. The collapsed sac was then excised by two curved incisions meeting at a point above and below the protrusion in healthy skin. Six or eight nerves were found attached to the internal surface of the translucent membrane forming the dome of the tumor. These were consequently dissected loose as close to the membrane as possible. On each side of the sacrum in front were seen similar nerves, but of larger size, entering the anterior sacral foramina. These, as well as the nerves dissected from the sac, came out of an opening at the upper portion of the sacrum which led to the vertebral canal. This opening would not entirely admit the tip of my little finger and was circular, being about three-eighths of an inch in diameter. In this opening lay what I supposed to be the cauda equina, which very nearly filled the entire orifice. This bony opening was situated very close to the upper edge of the external tumor, which had been developed principally below the opening rather than over it. The dura mater was apparently adherent to the internal surface of the tumor wall. The posterior wall of the vertebral canal in the sacral region was absent below the opening mentioned. The anterior sacral nerves were not interfered with, but the posterior ones with the cauda equina, or lower end of the cord, were pushed into, but not through the bony opening by my finger tip. The youth of the child and the serious character of the operation deterred me from undertaking an osteoplastic procedure, and even from interfering with the contents of the sacral opening.

The skin flaps left by the incision of the sac were then brought together over the site of operation by interrupted catgut

sutures. No drainage was used and the wound was sealed by strips of gauze saturated with iodoform and collodion. Some slight bleeding had occurred, but it was controlled without difficulty, and the sutures were applied so as to catch the vessels which seemed likely to bleed. A large mass of carbolized gauze was then applied and firmly held in place by a bandage. No ligatures had been required. The child slept after the operation and seemed to be reacting well.

The operation was completed about 3 P. M., having occupied about half an hour. In the neighborhood of five o'clock that same afternoon the nurse noticed some blood escaping from under the bandage. Attempts were made to stop this blood by pressure, without removing the dressing, but they were unsuccessful. At half-past nine I saw the child and removed the dressing, discovering that the bleeding came from a point at the upper angle of the wound, where pressure of the dressing was probably not as efficient as over the rest of the operative field. An acupressure pin was thrust through both margins of the wound and a catgut ligature wrapped around the ends of the pin in an elliptical manner. This readily stopped the bleeding. A similar pin was put at the lower angle of the wound as a precautionary measure, though it was not sure that any part of the bleeding came from that point. The upper pin was situated over the spot where the cauda equina had been pushed into the spinal opening, but was so inserted that no injury to the cauda or spinal nerves could occur. An iodoform and collodion dressing was again applied, and carbolized gauze adjusted outside of it. It is probable that the patient lost about an ounce of blood. Its lips, however, and finger tips retained their pink color, though the child looked paler than before the original operation.

I observed that the acupressure pins inserted deeply in the muscles of the back gave the baby no pain though this procedure was done without anæsthesia. It was evident, therefore, that there was a defect in the innervation of this region, as would be supposed from the nature of the congenital lesion.

Three drops of whiskey were administered about five times during the succeeding night and the following day. After the redressing the patient seemed quite

comfortable and needed no anodyne; and indeed none had been required previously. It slept comfortably, continued to nurse well, and seemed hungry.

The morning after the operation, at about 10 o'clock, the nurse observed evidences of nervous irritation shown by the head being bent backward, and some irregular muscular action of the eyes. The arms and legs, however, did not become stiff, and the baby did not cry or seem to feel pain. It, however, was very apt to start at sounds and had to be removed from a room in which a wood fire was burning, because the crackling of the wood thus annoyed it.

I saw the patient again at 5 P. M., having left in the morning about eight, before the symptoms of nervous irritation had shown themselves. Up to that time it had had eight or nine spasmodic attacks of the kind mentioned, and had taken since noon about three grains of potassium bromide in doses of one grain. This had been prescribed by Dr. Donnel Hughes, because of the evidences of nervous excitement. The nurse reported that the spasms had been less marked since the bromide mixture had been taken. Since morning the baby had refused to nurse, but had been fed with breast milk by means of a spoon. During my visit I had opportunity to observe one of these convulsive seizures. The head was quite strongly retracted by spasms of the posterior cervical muscles; the occipitofrontal muscle caused transverse furrows in the forehead, and the ocular muscles produced by their spasmodic action an irregular and varying strabismus. There appeared to be no spasm of the extremities and no real pain, for the child did not cry.

Before the occurrence of this seizure its pulse was 160 and not very weak; its respiration 60, and its temperature in the rectum 99.8°. The whiskey which it had been taking during the day, as previously detailed, was stopped, and the bromide mixture increased so that it received two grains every two hours unless asleep. No further hemorrhage had occurred.

Thursday night, September 28th, pulse, 116; respiration, 60; temperature, 98.4°. Friday morning, September 29th, pulse, 130; respiration, 59; temperature, 98.1°. The attacks of spasm ceased about 7 o'clock last evening, and were even before

that time not severe. At 4 P. M. there had been no further seizures, the child had taken its medicine and milk, which had been given with a spoon, and had a good movement of the bowels. The leakage from the bowel, which had previous to the operation been almost continuous, had ceased. The baby had been taking two grains of potassium bromide every two hours during the night and to-day, and had slept well. Friday evening, pulse, 136; respiration, 52; temperature, 97.6°.

On the morning of the third day after the operation, at 2 A. M., the child had a general convulsion which was followed by four others within two hours. The arms and legs became rigid, the gums were tightly clinched, the head drawn back, and the child's face cyanosed. The spasm seemed to involve all the muscles of the trunk, and even those of the scalp and face. One grain of potassium bromide was given every hour. After a few doses the convulsions diminished in frequency and severity. A slight one occurred about half-past seven, when no bromide had been taken for about two hours. The bromide was ordered to be continued, one grain every one or two hours according to the condition of the patient; and inhalation of one drop of chloroform directed to be administered if the convulsions were prolonged or frequent. The bandage was removed; the iodoform dressing opened immediately over the head of each of the acupressure pins, and these pins were withdrawn. The small hole made in the dressing was closed with absorbent cotton sealed with iodoform and collodion. A drop of brown blood oozed through the original dressing at the spot where the upper pin's point was situated. There was no evidence of sepsis and the original dressing was unsoiled and sealed the wound thoroughly. There was no escape or oozing of cerebro-spinal fluid observable at any time during the after-treatment of the case. The temperature at this time was 98.6°; pulse, 140; respiration, 46.

On the fourth day after operation I noticed oozing of some brownish fluid from under the lower part of the dressing near the gluteal crease. At this time the child had had no convulsion for thirty hours. Fearing that the proximity of the lower portion of the dressing to the



anus would lead to contamination of the wound by the escaping fluid becoming infected, I removed the iodoform and collodion dressing, which had been applied on the evening of the operation at the time I introduced the acupressure pins to stop hemorrhage. The wound was healed by first intention, except at the upper end, where there was a small gaping of the skin and a granulating surface. Across the upper and lower portions of the wound were lines of devitalized skin, rather grayish in color, evidently due to the acupressure. No cerebro-spinal fluid was escaping at any point. I was quite certain that the tissue which had been compressed by the acupressure pins would slough, but the rest of the wound seemed so healthy that I thought I should have little trouble with further local treatment. The wound was dressed with bichloride gauze after having been dusted with boric acid powder.

The dressing thereafter was changed daily. The wound however, did not do well. After the slough caused by the acupressure pins had separated, and on the twelfth day after operation secondary hemorrhage occurred from the upper part of the wound at very much the same spot from which the original hemorrhage had occurred a few hours after operation. This was treated by pressure and a new dressing. Two days later it recurred and was controlled by the introduction of two catgut sutures introduced at the point of bleeding. Death occurred fifteen days after operation from exhaustion due to the hemorrhage and the septic contamination from the sloughing surface. No autopsy was obtained.

The unfortunate result in this case was almost certainly due to infection of the wound occurring during the operation or at the time or the removal of the iodoform and collodion dressing on the fourth day. At that time, as has been stated, the wound was completely united. I noticed, however, a drop of purulent-looking fluid at the opening made by one of the catgut stitches.

Whether this catgut, which I had not prepared myself, was septic, and acted as the original focus of suppuration and sloughing, I am not able to say. It is possible that in many changes of dressing some fault in technique may have happened, as on one or two occasions the dressing had to be made under difficulties. The im-

perfect nerve supply of the part is to be taken into consideration as a cause of lessened resistance in the tissues when sloughing and suppuration once began. I have also thought that it possibly was an error to have used boric acid powder upon the wound daily, as the irritation of this drug may have aided in devitalizing the tissues already defective in nerve supply. I used the boric acid powder because I feared that otherwise the wound not be kept dry; and that if moist, infection by fecus or urine would more readily occur to vitiate the result. Until the secondary hemorrhage took place, I thought that the patient was on the road to recovery, although his temperature was rather high and irregular, on account of the sloughing process going on in the back. He took food well, seemed comfortable, and had very few convulsive seizures, which seemed to be easily controlled by bromide of potassium internally and chloroform inhalations.

#### Danger From the External Use of Salicylic Acid.

The *Schweizer Wochenschrift fur Pharmacie*, publishes the following: a few days ago, one of our country practitioners, who had long been troubled with sciatica, concluded to make a trial in his own case of salicylic acid, in alcoholic solution, as recently recommended for rheumatism. He applied compresses dipped in the liquid, renewed them several times in the course of the evening, and was getting ready for bed, when he was suddenly attacked by a feeling of general distress, violent itching, and roaring in the ears, then began to swell up, and finally lost consciousness. His family thought he was dying. A colleague who was hastily summoned found him enormously distended all over (as if by inflation of air) and profoundly comatose. A large dose of salicylic acid had been taken through the skin. Under the vigorous administration of stimulants and purgatives the patient revived; the swelling subsided, and in a few days he was able to be about. Salicylic acid ointment may also give rise to serious symptoms, as I have had the opportunity of observing in several cases. A single application is sometimes followed by such a degree of swelling and inflammation that the remedy has to be discontinued. These facts should operate as a warning to pharmacists, never to dispense salicylic acid except on a doctor's prescription."



## TRANSLATIONS.\*

## CARCINOMA AND ENDOTHELIOMA OF THE OVARY.

Dr. Vitalis Müller studied microscopically six ovarian tumors under the direct instructions of von Recklinghausen. The tumors appeared to belong to the above mentioned varieties.

Two primary carcinomas seemed to have originated in the Graafian follicles. One of secondary origin, whose primary seat had been in the uterus, appeared to have followed the lymph channels along the periphery of the ovarian peritoneal covering. These conditions can be explained only by accepting the theory of von Recklinghausen on "retrograde embolie." In a case of primary carcinoma of the supra-renal capsule, the epithelium of the ovarian stroma was found intimately connected with tubules lined with endothelium, and there seemed no reason to doubt that a secondary attack would have located itself in the ovary. Another tumor, belonging no doubt to the proliferating glandular variety, presented in the cyst wall epithelial layers anastomosing with each other and the lymph channels, producing the characteristic nodule. In the last case which belonged to the endothelial variety, the initial points being located in the wall of a glandular cystoma—it had originally been a multilocular

cyst about the size of a child's head—the inner surface was lined by a cylindrical epithelium with an ovoid nucleus. In the wall hollow spaces could be seen lined also with the cylindrical epithelium. Close to these glandular hollow spaces, a united tubular system existed, which was lined with cubical epithelial cells. At various spots these hollow spaces were surrounded by hyaline tissue degenerating into epithelial elements; in others papillomatous degeneration could be seen.

Careful examination of the last four cases led to the following conclusions.

1. If epithelial cells have entered into and multiply along the blood and lymph channels, a histological picture presents itself, which, in many cases, cannot be distinguished from an endothelioma of the ovary.

2. Intra-canalicular papillomatous formation following the course of the lumen of blood vessels, has not been heretofore observed in undisputed cases of cancer. No differential diagnosis can therefore be made in doubtful cases, unless a careful study under the microscope has preceded it.—*Arch. f. Gynaekol. bd II.*

—W.

## OPERATIVE TREATMENT FOR TUBERCULAR PERITONITIS IN CHILDREN.

The author (L. Conitzer), reports seven cases, four belonging to the exudative and three to the dry form. All were operated upon at the Jewish Hospital in Hamburg. The histories and results are given in detail, and the author presents the following conclusions:

1. Tubercular peritonitis can be cured spontaneously in the dry form comparatively less frequently than in the exudative type, which is cured in most cases.

2. The spontaneous cures of the exudative form of tubercular peritonitis, have heretofore been regarded as cases of chronic exudative peritonitis or ascites.

3. All forms of tubercular peritonitis

can be cured or at least improved by abdominal section, even though other therapeutic measures, including puncture, have been tried previously.

4. The result of the operation depends upon the form of the disease, (the best results being attained in the chronic variety), the previous duration of the disease and the eventual complications.

5. The operation is indicated when the internal therapeutics have proved of no avail.

6. The operation is contra-indicated in those patients of poor vitality, or in cases suffering from tuberculosis of other organs.

7. The question of how the cure is effected by abdominal section in these cases, has remained unanswered.—*Deutsch. Med. Woch.*

—W.

\* Translated for THE MEDICAL AND SURGICAL REPORTER by the translators M. B. Werner, M. D., and W. A. N. Dorland, M. D.

## ANATOMICAL CONSTRUCTION OF SOME OF THE GRANULAR SWELLINGS OF THE INTEGUMENT.

L. Philippson, (*Central. f. Allgem. Path. u. Path. Anat.* IV., 1893), has directed his studies to the *modus operandi* of infection, whether internal or external. His observations embraced chiefly syphilis, leprosy and tuberculosis. His studies resolved themselves into the following conclusions:

I. *Infection Externally.* First, syphilitic sclerosis; second, the superficial lepra nodes (?) found in the papillary layer surrounded by healthy tissue; third, superficial lupus nodes. These are all new growths, situated superficially, having sharp lines of demarcation, more or less round or concentric in form; the deeper structures are attacked later in the course of the disease.

II. *Infection Arising through the Cir-*

*culation.* First, roseola, syphilitic papules; second, acute erythematous spots or papules of lepra; third, efflorescence in miliary tuberculosis(?). These new growths at the onset extend in their development throughout all the layers of the cutis and follow along the ramifications of the blood-vessels.

III. *Infection through the Lymph Channels.* First, superficial nodes of leprosy developed above the cutis (?); second, miliary lupus originating from deep-seated infections.

The new growths of the third group, which may also belong to the syphilitic or leprosy type, cannot be distinguished by any regular appearance, and are rather flexiform in character.—*Schmidt's Jahr.* —W.

### Prophylaxis of Puerperal Diseases.

R. Frommel (*Deutsch. Med. Woch.*, No. 10, 1892), says that from April 1, 1887, to November 15, 1890, of 559 women confined, one died of puerperal fever.

Disinfection of the genitalia, after liberal use of soap and water, was effected by a solution of bichloride 1: 2000; the cervical canal also being carefully cleansed with the same.

From November 15, 1890, to December 11, 1891, there were 197 obstetric cases, in whom the external disinfection alone was used. Of these, 3 died of puerperal fever, and the percentage of those who were ill ran as high as 11.1. As a result of these observations, the author desires to emphasize the importance of external and internal antiseptics, as also that of personal cleanliness.—*Schmidt's Jahr.* —W.

### Spelling Made Hideous.

The *Medical Press and Circular* prints the following Philistine editorial: "Many of the American medical journals are now becoming so hideous in the matter of spelling that it is a difficult matter even for an ordinary educated English medical man to read them without wishing to

throw up his task in disgust. The van of this insane effort to appear novel is led by the *Philadelphia Medical News*, and now we learn that the editor of that journal is bringing out a new edition of a 'Medical Dictionary of Terms,' in which all this ne-fangled and absurd method of spelling will be incorporated. The rising generation of young American medicos are to be pitied if they are required to adopt the teaching in orthography which will obtain in this 'Dictionary.' We are glad to see that some of our leading contemporaries in the United States have not been led into disfiguring their columns by such words as 'chemic,' 'bromid,' and 'physiologic,' together with others equally absurd and hideous. The introducer of this *fin de siècle* method of spelling affirms that no argument can be advanced against it. But what about the rules of grammar and prosody so far as the English language is concerned. Perhaps under the circumstances it would be best at once to bring out a book dealing with the subject of 'The American Language: its Grammar and Orthography,' and then there would be no difficulty in showing that the American method of spelling had nothing to do with the English language."

# THE MEDICAL AND SURGICAL REPORTER

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SATURDAY, JANUARY 6, 1894.

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## EDITORIAL.

### PROSPECTIVE.

Entering upon this its forty-second year of continuous publication, the REPORTER sends greeting to the medical profession at large and to its friends and supporters, both old and new.

To its old friends but few words are necessary. You have appreciated and cordially acknowledged the REPORTER's untiring efforts to present to you what is latest and best in the medical world, avoiding discussions of abstruse matters and giving practical information that can be made use of in your every-day work.

It is utterly impossible to bring into the pages of any one journal the complete records of current medicine, but the entire field of medical science has been carefully and thoughtfully considered by the REPORTER and only the best and most useful of all available material brought under your notice.

The change that will appear most striking to you just now, is the reduction of the subscription price from five dollars to three dollars per annum. There will be no other radical change in the journal, but

a continuous, steady improvement will be made as opportunities may offer. Paid-up subscriptions for 1894 at the old rate, made before the change was announced, will cover proportionately greater time, and paid-up subscriptions at the old rate, beginning in 1893, but extending into the year 1894, will also be extended proportionately from the beginning of this year.

To our new friends it may be well to briefly state by way of introduction, that the MEDICAL AND SURGICAL REPORTER was among the very first of medical weekly journals to be established in America. Its continuous existence is sufficient evidence of its value to the medical world, and its large clientele demonstrates its influence and progressiveness. The journal has experienced the ups and downs common to journalistic existence—save that most common, failure,—and now, in its forty-second year, is in the prime of its life and influence.

It is not at all unusual, and is a most encouraging incident, for the REPORTER to receive from its older subscribers, who

have taken the journal continuously for years, congratulations on the maintained excellence of quality, independent attitude and progressive spirit displayed by it, together with the statement that the journal is better to-day than it has ever been.

You will expect to find the REPORTER a journal for the busy, every-day doctor. You will find in every issue something, at least, that will be of immediate service to you in your daily work. Its pages rarely contain lengthy technical discussions of abstruse subjects, however valuable to medical science in the abstract. There is not sufficient room, and there are other journals, more properly keeping these records. The physician in active practice, must have his facts presented to him tersely and pointedly. His munitions must be given him ready for use in the field. He has little disposition and no time for theorizing, experimenting or manufacturing. As he deals with human life, and recognizes his responsibility, he demands that his informant be trustworthy, and his information authentic. He will not risk life on the strength of hearsay, nor the assurances of advertising testimonials. The REPORTER brings him the best thoughts and experiences of the best minds in the profession, presented in a form readily apprehended and easily remembered.

As the progressive physician enlarges his knowledge and increases his success by studying the work of other men, it is his duty to his profession to allow others the benefit of his work and thought. There is no physician worthy of the name who cannot suggest something of value to others of the profession, and thus aid to advance the interests of his calling. The REPORTER desires to present such benefits to the medical world.

Again the MEDICAL AND SURGICAL REPORTER is a journal for the general practitioner. It cannot cover in detail

the work done in all of the numerous specialties, but, to give as wide a view as possible, the department of *Current Literature Reviewed* was established, and here will be found in briefest form to be intelligible, the most valuable articles contained in literature devoted to specialties. This review was a new departure in medical journalism and its value was so promptly recognized that many other journals have established similar departments.

In the *Library Table* will be found notices of the most valuable recent medical books, and reviews of these works at the hands of competent and unbiased reviewers, made entirely in the interests of the readers of the REPORTER.

The reports of foreign work are taken directly from foreign journals, and translated especially for the MEDICAL AND SURGICAL REPORTER.

*Abstracts* of the most valuable articles appearing in other publications are made and their sources acknowledged.

*Formulas* of tried value, and *Therapeutic Hints* from all proper sources, are regularly published, and the *Periscope* discovers miscellaneous items of interest and value not included in other departments.

A word with regard to our advertisers. Nothing is admitted to the advertising columns without keen scrutiny, and we are confident that our readers will find our advertisers in every way satisfactory and responsible. The policy of the REPORTER confines our advertisers to the advertising pages. Space in the reading columns is never sold, and reading notices are never given to individual advertisers. This, however, does not debar a discussion of any article which is deemed of sufficient interest to the profession, save in so far as such discussion would discriminate in favor of some individual advertiser.

The dilemma presents but two horns. All of our advertising patrons must be treated alike. Either the REPORTER must be conducted in the interests of the pro-



fession—a journal, with advertising however useful, incidental to medicine; or it must allow itself to be conducted by a variety of people, representing different interests, with medicine incidental to business.

The first has always been the policy of the REPORTER in common with all other

first-class medical journals and one we do not propose to vary, as both our subscribers and our advertisers approve of it.

We commend our advertisers to the profession as desirable to deal with and as parties not needing the questionable recommendation of constant mention in the reading columns of the journal.

## ABSTRACTS.

### A NOTE ON THE NATURE AND TREATMENT OF "INFLUENZA."

Mortimer Granville in *The Medical Press and Circular* says: Whether or not the malady misnamed "Influenza" be, as I believe it is, a Chinese marsh fever, there are certain characteristics of this disease which, with the indications obviously arising from them, have been unaccountably overlooked by clinical observers and ignored by practitioners. In view of the reappearance of the malady in our midst it may be worth while to point this out and to ask a reconsideration for the whole subject of pathology and treatment.

It was in 1848 that I first made the acquaintance of influenza, and in what would now be regarded as very adverse circumstances. I was engaged in the quasi-experimental study of the so-called system of "Homœopathy," which at that time almost fascinated the intellectual portion of London Society, and was the subject of thought and talk of every coterie. I happened to be in the region of densest fog, and it was not until some three years later that I succeeded in reaching daylight with the discovery that Hahnemann in his "*similia similibus curantur*" had either perpetrated an elaborate travesty of wit or become the victim of an extraordinary fallacy. However this may be, I have never regretted, indeed, I am daily thankful for, the close study of symptoms, states, and the direct and indirect action of drugs, dietary, and *conditioning*—what we now call "nursing"—on the organism in disease I was thus led to pursue. In respect to influenza, three facts which then came to my knowledge are of such practical value that I would not for any consideration be ignorant of them; and

yet, so far as I know, they are not even mentioned in any text-book of medicine or in any special treatise on this disease. Briefly they are these: 1st. The temperature—we had no clinical thermometers in those days, but estimated bodily heat tolerably correctly by the hand—is a bogus one. It is not inflammatory, and a fatal mistake would be, and, as a matter of fact is, made by so treating it. 2nd. There is *always*—though in a large proportion of cases overlooked, lobular, or broncho-pneumonia, that is active congestion of the lining membrane of the bronchial tubes extending to their cells at the outset of the disease. Very often the area of dulness—from engorgement—is so limited that it is not perceived, and it may change from place to place, in the same lung, or disappear in one lung and make its appearance in another in less than two hours. Important, almost pathognomonic as the existence of this broncho-pneumonia is, it does not necessarily produce any special symptom drawing attention to the fact. This is why practitioners fail to observe it, and it explains the absurd description "Influenza complicated with pneumonia." Broncho-pneumonia is the very essence of the disease, and it would be far better to call it "epidemic lobular pneumonia," and thereby avoid a world of confusion and mischievous mistake. 3rd. The treatment must be tonic throughout, and the diet especially nutritious and stimulating *ab initio*.

These were the facts learned in 1848. The explanation has come with recent years and fuller knowledge.

The high temperature is bogus, because

it is simply the results of a sudden transference of normally hot or only slightly super-heated blood from the deep vessels to those immediately under the skin and in the mucous membranes. This is the direct effects of poison on the nerve centre, the poison of epidemic bronchopneumonia acting specifically upon the vaso-motor centre. After the rush of the blood to the surfaces, external and internal, there is sometimes a rapid reversal of the state of matters and the blood falls in again upon the deeper vessels, and particularly those of the liver and kidney. When this occurs the temperature falls suddenly to a subnormal point. These are not, however, the worst cases. If the effects of the poison on the vaso-motor centre are sufficiently powerful to "stagger"—almost paralyse it—the result will be asthenic dilatation of branches of arteries supplying special lobules of the lung, with result of immediate hypostatic congestion. If this last long enough in any particular region a typical pneumonia may be fully developed; but it frequently happens that the particular nerve affected recovers and the muscular fibres of this artery act again, while another branch or filament supplying some other lot shows the paralyzing effect of the poison. The poison still acts on the centre, but its influence passes from branch to branch of the vaso-motor nerve. All this time it is possible that the blood state, as distinguished from the blood-vessel state, may be natural. The mean temperatures of the blood is, as we know, 39° C., or 31.2° Rean, or 102.2 F. (a very common temperature early in influenza). So that the mere transfer of naturally hot blood to the surfaces accounts for a great part of the temperature observed. If the action of the poison on the vaso-motor centre be prolonged nutrition is disturbed and a slight rise will rapidly bring the temperature to 104. or 105°. Indeed some physiologists place the mean of the blood heat at 40°C., which would give 104F. or 32°R. at the outset.

The point to note is that the great factor in the production of the high temperature in influenza is the bringing of normal blood to the surfaces *i. e.*, within reach of the clinical thermometer, and that this phenomenon is a result of "shock" to the vaso-motor centre, and needs to be treated by stimulants not by

depressants. In such a case the coal-tar derivatives, antipyrine, etc., are simply murderous agents, and I do not hesitate to affirm that cases of influenza treated by these drugs are placed in jeopardy by a blunder in art, and that the mortality of the disease has been in great part the effect of the treatment. The depressant came into action at the moment of collapse, and rendered recovery impossible.

I believe the best treatment of influenza—or as I prefer to call it epidemic bronchopneumonia—to be by camphor and iodine combined, as follows:—

**R** Camphoræ, ..... gr. lx;  
Tincture iodi, (a) ..... m lx;

(a) To avoid the depressing potass iod. so strangely introduced in the tinct. iodi of the "Brit. Pharm."

Mucilaginis acaciæ, ..... Siv;  
Glycerini, ..... 3vj;  
Olei menthæ piperitæ, ..... m vj;  
Syrupi zingiberis, ad..... 3ijj.

Two teaspoonfuls being given every second or third hour until recovery happens, with clearing up of the lung congestion. Meanwhile—*during the stage commonly regarded as inflammatory*, be it observed—a highly nutritious diet of meat-juice or very strong beef-tea with a sufficient allowance of champagne or brady must be insisted upon. Rarely does the malady persist more than from three to five days, and when it subsides the patient is so little exhausted that the convalescence is extremely short. The chest should be daily, sometimes twice or three times in the twenty-four hours, searched for suddenly appearing or lingering patches of congested lung, and hot stupes of turpentine or mustard poultices applied if delay occur in the recovery of the arterial tone.

I do not urge this or any other particular mode of carrying out the indications, but I maintain that these are to make a vigorous attempt to arouse and support the action of the vaso-motor centre; and to avoid anything and everything caused by any chance depression. It is not an inflammatory disease we have to combat, but a poison which threatens to kill our patients by mere collapse, and the high temperature, the congestion, and the neuralgic pains are symptoms directly arising out of, and fully explained by the inhibitory effect of the poison upon the nerve center in the manner and with the results described.

## TYPHOID FEVER AND DRINKING WATER.

We have 50,000 deaths annually from typhoid fever, and we know how to prevent these deaths. Why do we not do it? It is estimated that the life of the average adult is worth to the State \$1,000. If a young man of from twenty to twenty-five years of age loses his life, it will cost \$1,000 to raise another up to the same age; and I am sure that any father who is engaged in the pleasurable occupation of raising a family of boys will deny that it can be done so cheaply. But on this estimate, this Government is losing 50,000 times \$1,000 or \$50,000,000 annually in death from typhoid fever. This is not all that typhoid fever is costing us. For every death from this disease, at least ten other people are sick with it. Five hundred thousand people who do not die are sick each year with typhoid fever. We will suppose that the average duration of the sickness is twenty-eight days, and all physicians will agree that this estimate is too low. The person who has typhoid fever is often unable to resume his vocation within a shorter time than three months. However, we will make our estimate on the supposition that the average time lost from work by a man sick with this disease amounts to 500,000 times twenty-eight days, or 14,000,000 days which is equivalent to more than 38,356 years. Supposing that the time of the individual is worth 50 cents per day when he is well, this represents an actual loss of \$7,000,000 annually, and this should be doubled, because for every person sick the time of another person who acts as a nurse is demanded. The \$14,000,000 added to the \$50,000,000 which is lost by death makes a total sum of \$64,000,000 or about \$1.00 for every inhabitant, the annual tribute levied upon this Nation by the one disease, typhoid fever. This represents approximately the amount which we pay every year for the ignorance and carelessness which we exercise in allowing this preventable disease to prevail among us.

I have said that typhoid fever is a preventable disease, and that the large number of deaths from this disease is unnecessary. This is true, not only theoretically, but practical demonstrations are not wanting. Prior to 1859 the city of Munich, in Bavaria, was a veritable hotbed of typhoid fever. There were no

sewers and no public water supply. Most of the houses were furnished with large brick or wooden flues which were built from the cellar up through the different floors. Into these the excretions from the body were dropped and accumulated in the cellars. Other waste material was deposited in cesspools, and garbage was thrown into back yards. The air in the houses was foul and offensive to the sense of smell. The drinking water was taken from shallow wells in the yards, and these often received the ooze from the cesspools and vaults. In 1859 the citizens were compelled to seal tightly the bottoms and sides of these receptacles of filth, and later, a system of sewerage was introduced, and later still a supply of wholesome drinking water was obtained. Notwithstanding the fact that portions of the city still remained unsewered at the time of the last report, the results have been most gratifying. From 1852 to 1859 the typhoid deaths per 1,000 in Munich averaged 24.2. This has been gradually decreased, until in 1884 it was 1.4 per 1,000. This shows what has been done in an old and crowded city, and Vienna has practically repeated the demonstrations made by Munich. The majority of cases of typhoid fever arise from a contaminated water. That a drinking water infected with the discharges from a person sick with typhoid fever may cause an epidemic of the disease, there can no longer be any doubt. The records of sanitary science abound in histories of such cases. Every physician of large experience with this disease can detail one or more instances in which the disease has been clearly traced to infected water and I will consider that this method of the dissemination of the disease is recognized by all. It probably is a safe estimate to say that bad drinking water causes not less than 40,000 deaths each year in this country.—*Prof. Victor C. Vaughn, M. D., in the New York Independent.*

First Tramp—"These Fifth Avenue people are very unreasonable with us."

Second Tramp—"Yes; never give money, and lecture you for being dirty."

First Tramp—"And yet, when I rang and asked for a bath only, I was refused."  
—*Life.*

# PROLONGED INTERMITTENT TREATMENT OF SYPHILIS.

Prof. E. Lang read a paper before the Medical College of Vienna in which he criticised the treatment of syphilis advocated by Prof. A. Fournier (Paris), who has now been induced, as the result of a long experience, gradually to increase the duration of the treatment from nine months, as recommended by him several years ago, to five or six years.

The author is of the opinion that the method devised by the distinguished French syphilographer is not in conformity with the natural evolution of syphilis. Syphilis being a curable affection at any stage of its development and even before the appearance of the secondary manifestations, it is evident that no single method of treatment will do in all cases. The therapeutical means employed must necessarily vary according to the necessities of each individual case.

In a recent publication (*The Medical Week*, 1893, Vol. I, p. 35), Prof. Fournier gives some statistics based on 1,703 cases of tertiary syphilis which, from the point of view of the duration of the treatment, may be classified as follows:

No treatment.....	217 cases.
Treated for less than one year.....	1,162 "
"    from one to two years.....	265 "
"    for more than two years,	53 "
"    for more than three years,	6 "

Prof. Fournier concludes, therefore, that out of 1,703 cases of tertiary syphilis, only 59 occurred after, and in spite of, conscientious treatment, while in the remaining 1,644 cases the accidents were due to the fact that the patients had only been very imperfectly treated, if at all.

Prof. Lang pointed out that supposing Prof. Fournier still believed that twelve months' treatment were sufficient to cure syphilis, he (Prof. Fournier) would be obliged to admit, in presence of the foregoing statistics, that tertiary manifestations occurred in 217 patients who had not been treated and in 324 (265 + 53 + 6) who had been submitted to appropriate treatment for the required period of time. The obvious conclusion would then be that, so far as the tertiary manifestations are concerned, prolonged treatment is worse than total absence of treatment.

To show that cerebral syphilis can be prevented by his method, Prof. Fournier

quotes 100 cases of syphilis of the brain which can be tabulated as follows, according to the duration of the treatment:

Prolonged and conscientious treatment.....	5 cases.
Treatment of average but insufficient duration, 6 "	
"    for from 7 to 18 months.....	10 "
"    for from 1 to 6 months.....	70 "
No treatment.....	4 "
Treated by iodide of potassium alone.....	5 "

This table shows, according to Prof. Fournier, that "only 5 out of 100 cases of cerebral syphilis had been submitted to conscientious treatment, while in the remaining 95 cases the treatment had been *nil* or only very imperfect or of short duration. From which it follows that cerebral syphilis is 19 times less frequent after conscientious treatment than in patients who have not been treated at all or only very imperfectly."

This statement is open to the same objection as the statistics already quoted, and Prof. Lang believes that the following conclusions may equally well be drawn from the facts brought forward by Prof. Fournier, showing how far the figures given by the eminent specialist are deceptive:

(1) Five patients out of 100 have taken nothing but iodide of potassium as against 95 who have either not been treated at all or have been submitted to some other method of treatment; from which it follows that cerebral syphilis is 19 times less frequent in patients who have been treated by iodide of potassium alone than in those who have taken mercury or nothing at all.

(2) In four cases out of 100 no treatment was applied, while in the remaining 96 mercury or iodide of potassium was administered; from which it follows that cerebral syphilis is 24 times less frequent in cases in which no treatment is employed than in those in which mercury or iodide of potassium is administered.

Indeed, Prof. Fournier himself admits that he has met with cases of recovery from syphilitic disease of the brain in which the patients had undergone a prolonged course of treatment, as well as with cases in which the patients remained free from specific manifestations of any kind, eight, twenty-four and even thirty-four years after a short period of treatment.



So far from exerting a favorable influence in cases of syphilis the method of prolonged treatment recommended by Prof. Fournier is apt, according to the author, to produce a deleterious effect on the patient's general health by giving rise to various alimentary troubles associated with insomnia and other nervous symptoms of a somewhat grave description, and favoring the occurrence of tertiary manifestations. For example, the statistics communicated by Prof. Fournier to the First International Congress of Dermatology in 1889, show that the liability to tertiary manifestations increased in his patients until the third year after infection, a fact which is in direct opposition to the experience of the advocates of the "opportunistic" method who have never met with the same liability to tertiary accidents during the first three years after infection in the patients under their observation.

The statistics communicated by Prof. Fournier to the Congress were based on a series of 3,429 cases, in 1,085 of which the nervous system was the seat of syphilitic lesions, a very large proportion, even after deducting the 355 cases of tabes which are regarded by the distinguished French syphilographer as of syphilitic origin.

Lastly, Prof. Lang pointed out that Prof. Fournier has never reported a single case of reinfection in patients treated by his method, the occurrence of reinfection being a most conclusive proof that the patient had been completely cured of his first attack of syphilis. Another disadvantage of the prolonged treatment consists in the fact that certain patients are very liable to relapses irrespectively of the method of treatment to which they are submitted; if such patients are already under the influence of mercury the administration of this remedy is not attended by the same success as it would be under other circumstances.

Dr. Finger spoke in favor of the prolonged treatment of syphilis. He maintained that so far as the liability to tertiary manifestations was concerned it was inaccurate to say that it was increased during the first few years after infection under the influence of the prolonged treatment.

Dr. Mauriac also communicated in the First International Congress of Dermatology some statistics on the same subject,

from which it would appear that the tendency to tertiary accidents is greatest between the third and the sixth year, after which it gradually decreases. These facts were confirmed by the observations of Haslund and Leloir.

With reference to syphilitic diseases of the nervous system it should be borne in mind that this category comprises, according to Prof. Fournier's classification, such affections as locomotor ataxy, progressive general paralysis, the various amyotrophies, etc.; hence the large number of cases of this kind reported by this observer. As a matter of fact, Dr. Mauriac arrived at the same conclusions. It must be admitted that the prolonged internal administration of mercury is apt to give rise to various troubles, which can, however, be avoided by exhibiting the remedy in the form of external applications. Moreover, reinfection is not a conclusive proof that the individual had completely recovered from his first attack of syphilis, for there are a few cases on record of patients who had been reinfected while suffering from typical tertiary manifestations. The principal argument in favor of the prolonged treatment is the necessity of preventing the occurrence of tertiary accidents. It is generally recognized that the milder the secondary the greater the liability to tertiary manifestations; this is due to the fact that the treatment is seldom continued for any length of time when the disease assumes a mild type to begin with. Consequently some of the virus remains in the organism where it sets up various pathological processes at a subsequent date in the absence of appropriate treatment.

It is more rational, therefore, to combat the effects of the virus without interruption. The tissues being the seat of infective processes for three years after inoculation, the patient should be more or less under treatment during the same period of time. To prevent mercury from accumulating in the system, the administration should be suspended at intervals to permit of the elimination of the remedy. In concluding, the author said that he had employed the method of prolonged treatment for the last ten years with very satisfactory results.—*Medical Week.*

Cleanliness is next to godliness; but small boys should not go swimming on Sunday.

## ON THE CARE OF INFANTS AND YOUNG CHILDREN ACCORDING TO THE BIBLE AND TALMUD.

The following is an indication of the subject-matter of Dr. Finlayson's article in the *Medical Magazine*, October, 1893:—

The Talmud gives direction to the pregnant and the nursing woman as to the management of her health, particularly in the matter of diet, and it indicates the evils that may be expected to result from a violation of these rules.

The foetus was believed to originate from three sources—the father, the mother and the Lord. To the first it owed the white portions, whence were derived the bones, nerves, whites of eyes, etc. The second contributed the red portions, from which were developed the skin, flesh, colored part of the eyes, etc. God gave the spirit, the intellectual faculties, and the power of movement.

The Talmud teaches that an angel takes charge of the embryo from its very beginning, and educates the foetus "in all sciences, but especially in the study of the Mosaic and Rabbinical laws. At the moment when parturition begins however, the angel gives it a slap on the mouth, and all it has learned is forgotten."

An explanation is given of the origin of sex. If the male seed gets first into the womb at coitus, a female child is the result, and *vice versa*. Indications, too are furnished for the determination of the sex before birth. Thus, "a woman who is pregnant with a male child ought to have a better complexion, and the quickening should occur earlier, and parturition also ought to be easier and less painful. The last mentioned circumstance is especially insisted upon by the Talmudists."

Hermaphrodites were excluded from civil and religious rights, but operations were performed to remedy some malformations such as imperforate anus and hypospadias. Allusion is here made to the tradition that Moses and Job had congenital absence of the prepuce.

The desire for male issue was strong among the Jews, and Rabbi Elazer knew how to take advantage of it. He says, in answer to the question, "What is a man to do in order to beget male children?" "Let him disperse his money among the poor in alms."

The expression "stool," "stools," or "birthstool," which occurs in Pharaoh's order to the Hebrew midwives, has given

rise to much discussion, and question cannot be regarded as settled. It is possible that "upon the stools" of the authorized version ought to be rendered "on the wheels"—i. e., before the potter's vessel comes off the wheels, the idea being (and this view is supported by the midwives' reply to Pharaoh) that Pharaoh intended that the babes should appear to have been still-born and not to have been killed.

The fact of the prolonged period of separation of a woman after a female birth as compared with a male birth (as enjoined in Leviticus) is familiar to all and must appear strange to modern obstetricians. There is no doubt, however, that in the times of the Talmud, the idea was generally prevalent that a labor which resulted in the birth of a female child was more severe than that which gave birth to a male. To account for this supposed fact, a writer in the Talmud says that the female foetus turns around before birth, so as to present with the face anteriorly, while the male presents with the face posteriorly. Curiously enough, a pseudo-Hippocratic writer describes the period of lochial purification as being from twenty-five to forty-two days for a girl, and twenty to thirty for a boy. His explanation, however differs from that of the Talmud.

The subject of circumcision naturally receives much attention from the Hebrew writers, and in the Talmud also expression is given to the popular notion that "the child born at the term of nine months, or of seven months, is regarded as viable, but it is considered not viable if born at eight months."

The Talmud further gives rules for deciding the question when a child has been actually born. It indicates the circumstances under which an operation compromising the life of the child is justifiable and ordains the breathing in of air as the means to be used to resuscitate the apparently still-born.

The after-birth was sometimes treated with oil, and wrapped in wool or cotton, as a sympathetic measure calculated to warm and revive the new born infant.

The Hebrew writers inculcate the duty that devolves upon mothers of nursing their own children, but abundant reference

is made to other nurses and it is probable that wet nurses were sometimes hired.

"In three different cases, females ought to make coition unfruitful by using a tampon in the vagina—viz., a delicate girl still immature, a pregnant woman, and a woman who is suckling. The first, so that, if she chanced to conceive, she may not have to atone for parturition by her life; the next so that a second foetus may not be formed, and press to death the one already in the womb; and the last, so that her babe may not be caused to pine away by the occurrence of pregnancy."

"Nursing women do not menstruate because the blood is transformed into milk."

The weaning of children is often referred to. A very instructive allusion occurs in 2 Macc. vii, 27:—"O my son, have pity on me that bare thee nine months in my womb, and gave thee suck three years, and nourished thee, and brought thee up unto this age, and endured the troubles of education."

The prophet Isaiah speaks thus of the growing child:—"Butter and honey shall he eat when he knoweth to refuse evil and choose the good."

### INTRAVENOUS INJECTION OF SALINE SOLUTION IN SEVERE HEMORRHAGE.

Dr. P. Horricks read a paper on this subject before the Obstetrical Society of London. He pointed out that injections of various fluids had been recommended for centuries in cases of severe hemorrhage, but it was Dr. Wooldridge who first advocated the use of normal saline solution in place of blood, the injection of which he said was attended with great danger and was less efficacious. Following up Dr. Wooldridge's ideas in this subject he had published his first successful case in 1891. He referred to the following theories and facts which had led up to the practice of saline transfusion:—(1) Death from hemorrhage results from failure of the heart caused by distension due to the great and sudden fall in the blood pressure; (2) In death from hemorrhage sufficient fluid remains in the blood vessels to carry on life if it could be made to circulate; (3) Theoretically, half the volume of blood could do the same work if it were given double the velocity; (4) The blood pressure could be raised if as much fluid were transfused as there had been blood lost. Dr. Wooldridge performed an experiment with two dogs as nearly as possible alike in size, etc. Both were bled to death, *i. e.*, until they had ceased to breathe and were pulseless. One was left untouched and never showed signs of life again. The other was transfused, the water used being equal in amount to the quantity of blood removed. The dog immediately jumped up and recovered without any signs of ill-effect. Since September, 1891, this method had been largely used not only in

hemorrhage but in collapse without hemorrhage, though personally he had had no experience of its employment in the later condition. He would be afraid that the overfilling of the vessels might determine death from over-distension of the heart when the reaction set in. He thought, however, that no case of loss of blood should be allowed to pass without an attempt being made to revive the patient by transfusion. In all the cases referred to later the patients were pulseless, but he pointed out that even if a patient were not actually pulseless he or she might nevertheless have lost enough blood to determine death. Death in such cases was attributed to shock, etc., though in reality it was due to loss of blood. He had never seen any harm follow transfusion except a little suppuration at the wound over the vein.

*Case 1.*—E. L., æt. 29, was the subject of an extra-uterine gestation of some five weeks' standing which had ruptured, determining severe internal hemorrhage. She was immediately operated upon, but the quantity of blood effused was so great that she appeared to be moribund, breathing having ceased and the pulse at the wrist being imperceptible. The case appeared hopeless, but transfusion was persevered with until some *six pints* of saline fluid had been infused. The pulse gradually returned, and she recovered without a bad symptom, except some suppuration along the drainage tube.

*Case 2.*—The patient, æt. 33, had her last period November, 1892. She had an attack of pain in the abdomen on Febru-



ary 13th, and again on the 16th, when she became blanched. The circumstances being unsuitable for operation in the house she was brought to Guy's Hospital where she was immediately operated upon. It proved to be an ectopic gestation, and after the operation the patient was carried back to bed pulseless and hot water containing 5 j to the pint, of salt was injected until five pints had been transfused. The pulse returned. The patient made a good recovery though her temperature went up, reaching 101° on the 4th, and 103.4° on the 8th day, with vomiting and diarrhoea."

*Case 3.*—E. S., æt. 28. Had seen nothing for two months, though usually regular. A fortnight before she had been seized with acute pain in the abdomen with vomiting, and she passed blood *per vaginam*. On October 26th, on getting out of bed she fainted and became very pale. Before the operation the patient became quite pulseless, and intravenous injection was commenced as soon as the pedicle was tied. Six pints of saline solution were injected, and she made a good recovery.

*Case 4.*—A. T., æt. 36, in the seventh month of her eleventh pregnancy. had severe hemorrhage. Podalic version was done, during which the patient became pulseless and saline injection was begun when the pulse once more became perceptible at the wrist. An hour later it became imperceptible, so more saline solution was transfused, but in spite of a further improvement the patient sank and died. Post-mortem, a large effusion of blood was found in the left broad ligament with a tear in the cervix extending into the broad ligament. There was no blood in the peritoneum.

*Case 5.*—J. M., æt. 44, was admitted to Guy's Hospital with hemorrhage, due to cancerous growth of the cervix. The growth was removed by means of the galvano-cautery, but owing to its becoming too heated, copious hemorrhage followed. The patient became very collapsed and the pulse was almost imperceptible at the wrist. Just over three pints of saline solution were injected. The patient recovered in spite of the fact that both broad ligaments had been cut into, and the base of the bladder damaged.

*Case 6.*—This was another case of ruptured tubal pregnancy, and copious hemorrhage followed the partial detachment

of the placental mass. Much time was also lost looking for a sponge which was erroneously declared to be missing. The patient was very prostrate, and seemed at death's door. Six pints of saline solution were injected but the patient succumbed on the fourth day from suppurative peritonitis.

*Case 7.*—This case was that of a young married woman who soon after marriage developed tubal gestation. Operative assistance was refused for the moment, but subsequently he received a telegram that the patient was being brought to the hospital. She expired however as she was placed on the operating table. Brandy was injected subcutaneously, artificial respiration was tried, and then his assistant commenced intravenous injection, but with absolutely no result. After a few pints had been injected he opened the abdomen and removed the specimen of ruptured tubal gestation, which he showed. This case, he pointed out, showed the danger of delay, and also demonstrated the fact that the heart and vessels did not long retain their power of carrying on the circulation if once stopped. He suggested that the procedure offered a better chance of success when the bleeding vessels could be secured before transfusion was begun.

Dr. Herbert Spencer reproached the author with not having referred to his (Dr. Spencer's) observations on this point, his case, published in April, 1888, being the first in which the transfusion of normal saline solution was resorted to. He agreed that a trial ought to be made of this method in every case in which death from hemorrhage was threatened, but he urged that there should be greater accuracy in the proportion of salt used. He asked what physiological authority the author relied upon to prove his assertion that pure water might be used with impunity. By using a jug instead of a funnel the necessity for skilled assistance was dispensed with. The injection of very hot or very cold water might be followed by syncope, and some danger also attended too hasty an injection. In some cases, where the jug had been held too high, he had noticed recurrent pulsation in the veins, pointing to over-distension of the heart. He did not think that six pints was the outside limit of the injection, and in case of necessity he would not hesitate to employ more.—*The Medical Press.*



## CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D.

## THE ANNALS OF GYNECOLOGY AND PÆDIATRY

for December. Dr. Frank W. Talley contributes a paper on

*Irrigation of the Non-puerperal Uterus.*

The instrument used by the author for the operation consists of a small canula, slightly bent at its uterine end to facilitate introduction, perforated at the end and sides, allowing the escape of the irrigating fluid in every direction, and provided with two pieces of wire soldered to its side, so that a space may be preserved between the canula and uterine wall, permitting the return flow of the fluid, and providing for the washing of the mucous membrane of the uterine canal throughout its course. The instrument has been made of such size as will just pass through a No. 15 French catheter scale. For convenience in office practice the author uses a speculum having the lower valve guttered and provided with a funnel on its distal end to which a rubber tube may be attached leading into a slop-jar placed at the foot of the table. The fluid used in the irrigation consists of a solution of one drachm of bicarbonate of soda, and thirty grains of carbolic acid to the quart of water at 110° F. From two to four quarts of such solution are used. The author advises that the cervix be mopped with a solution of carbolic acid 1:40 in order that no septic matter be carried into the uterus. The conditions which the author believes particularly applicable to the treatment are endometritis, metritis and subinvolution. He states that there is no danger of uterine colic if all the solution is allowed to drain away, and the uterus permitted to empty itself before the canula is withdrawn.

*Pelvic Congestion*

is discussed by Dr. Almon Clarke. The author believes that pelvic congestion is accountable in a great measure for the persistent nausea of pregnancy. Post partum hemorrhage he also attributes to the same cause and instead of the use of ergot recommends morphia and the tampon. Afterpains he also regards as the result of engorgement of the uterine vessels. The cause of the congestion he thinks in the majority of instances is constipation and the accumulation of feces in the large intestine and wherever pelvic congestion exists fecal accumulation should be looked for. If not found the case should be treated as if it were a known fact, and the treatment will often prove its existence. The treatment therefore should be directed to the relief of the accumulation of feces and should consist in clearing the whole length of the colon and keeping it clear, and afterwards promoting absorption and strengthening the weakened blood vessels by massage, electricity and such other local and general treatment as may be indicated.

Dr. Charles P. Noble presents the

*Report of Two Years' Work in Abdominal Surgery at the Kensington Hospital for Women, Philadelphia.*

Ninety-nine cellotomies have been performed with five deaths, none of which were due to infection on the part of the operator. The importance of early operation in pelvic troubles is urged by the author. In regard to the matter of the use of drainage, the author says that the only evil which he can attribute to drainage in his hands is that it prevents a perfect apposition of the abdominal wound and, therefore, he believes it is a predisposition to hernia. He drains all septic cases and all cases which he believes to be septic and all cases in which he expects much leakage after the operation. Gauze drainage he thinks is of value in certain cases. In incomplete operations and when there are extensive raw and vascular surfaces, he thinks it a most useful addition to the surgeon's armamentarium, but these conditions are seldom met with. It is to be used wherever the surgeon wishes to favor the formation of adhesions, which fact shows that its usefulness is limited, because, as a rule, adhesions are not to be desired. The author advocates the Edebohls method of suturing the abdominal wound by means of a row of buried sutures. Appended to the paper is a table of the operations performed.

Dr. Joseph Price presents the "Report of a Group of Interesting Cases of Abdominal Surgery." He reports the removal of an ovarian tumor from a lady aged 75 years. He dwells especially on the advantages of drainage in proper cases, the dangers and disadvantages of the use of opium in any form and the necessity of a previous surgical training in those who would undertake abdominal surgery.

Dr. M. A. Poncet contributes an account of the final illness and death of Dr. Emil Blanc from a very acute septicemia of puerperal origin, through infection of the finger. The infection was received during the removal of the debris of the placenta from one of his patients, who was suffering from puerperal inflammation.

Dr. Thadeus A. Reamy reports the "Removal of Fibro-myomata with the Pregnant Uterus, Eleven Weeks Gestation, by Baer's Method. Recovery."

In the Department of Pædiatry is the report of a clinical lecture by Dr. H. Augustus Wilson on "The Mechanics of the Human Foot and Cases Illustrating Lost Mechanical Functions and their Restoration."

## THE PACIFIC MEDICAL JOURNAL

for December. Dr. Harry M. Sherman describes a

*Splint Opener for Plaster-of-Paris Splints*

and other simple devices. In the saw for cutting the splint the back of the saw blade

is ground down to a knife edge for about an inch back from the point. Ten teeth to the inch have been found to make the best saw. The handle is put on a higher level than the blade by means of two elbows. The opener consists of two blades and handles joined so that when the blades handles are approximated, the blades are separated. The blades, when in contact, will just fit in the cut made by the saw and are held from slipping on the plaster by little serrations.

As regards the most convenient places for sawing the splints: on the upper arm the cut should be along the external surface, and if the splint is a spica of the arm and trunk, a second cut must be made through the trunk portion under the arm of the opposite side; on the arm and forearm the cut should be along the posterior aspect of the arm, over the tip of the elbow, and along the ulnar border of the forearm; on the forearm and hand it should be along the radial border of the forearm and hand and thumb, and the outer side of the forefinger.

In splints of the lower extremity, a spica of thigh and pelvis should be cut down the inner aspect of the thigh, and the pelvic portion over the ilium of the opposite side; on the thigh and leg the splint should be cut down its outer aspect; all splints that take in the foot should be cut down their posterior aspect and then along the sole of the foot.

The author also describes an aluminium chin collar and fork for use in supporting the head in cases of disease of the cervical vertebrae, and a night shoe for cases of talipes.

In the treatment of hip-joint disease by traction in bed, or in the treatment of cases after resection of the hip, or in any case where there is a tendency to rotation outwards or inwards at the hip, the foot-holder described in the paper is useful. It is merely a sole of wood fastened by its heel at right angles, to the middle of a slat of wood about ten inches long. The sole is strapped to the foot by webbing, somewhat as the old-fashioned skates were strapped on, and the slat lying on the bed prevents any rotation of the limb. A peg projecting from the toe of the wooden sole is to hold the bed clothes up from the foot.

The fastening of webbing and plaster and buckles *et id omne genus*, is a tedious process by needle and thread, and the eyelets ordinarily used weaken the material by cutting threads. The simplest way is by steel wire staples fastened by the hand-staple press, such as can be bought at any large stationer's store, and are intended for fastening manuscripts and pamphlets. These are easily adjusted, hold firmly as long as they are needed and then are removed with little difficulty.

Dr. S. R. Mather reports "A Fatal Mistake" made by a French surgeon where the small intestine was found firmly sewed up in the wound made during an abdominal section. Symptoms of strangulation ensued soon after the operation but the surgeon had gone from the city and did not return in response to a telegram still the patient was moribund. She died during an operation for relief of the strangulation.

Dr. W. F. Southard concludes his paper on "The Modern Eye" and Dr. Gustav Dresel

discusses the subject of "Ophthalmoplegia," reporting an interesting case.

#### THE NEW YORK JOURNAL GYNECOLOGY AND OBSTETRICS,

for December. Dr. William M. Polk contributes a paper on

##### Hysterectomy (Supra-public) for Salpingitis and Ovaritis.

He does not accept the proposal in whole, because by so doing, all idea of conservative surgery in dealing with the appendages is necessarily abandoned. He believes however that the uterus which is deprived of its appendages is not only useless to the individual but is a source of positive evil, and that the dangers of the operation are insufficient to forbid its application in the usual case of salpingitis. He says to those who repudiate conservative operations upon the appendages that complete work demands the removal of the uterus along with the appendages; and to those who accept conservative operations upon the appendages that when these organs are sacrificed the principles of conservatism to not apply to the uterus which should then be removed. He is of the opinion that the Trendelenberg position is a necessity in performing the operation and advocates the complete operation by means of ligatures instead of the nœud.

Dr. Marcus Rosenwasser discusses

##### The Uterine Sound Its Use and Abuse.

He describes the instrument, its indications and use as well as the counterindications and abuse. He lays down the following laws in regard to the instrument:

1. Let none use the sound who have not the necessary experience in bimanual palpation to make an approximate diagnosis in pelvic disease.
2. Strict asepsis of hands, instrument and field of examination are enjoined.
3. A thorough familiarity with the technique is essential.
4. Use the sound only for necessary information concerning the inside of the uterus not otherwise obtainable; or to induce early abortion; or to assist in replacing a movable uterus in exceptional cases.
5. Don't use the sound when irritation or inflammation already present would be increased; or when it would be the carrier of disease products or germs; or when its use would be likely to cause injury to agglutinated organs; or lastly, when the information gained would be inessential.

Dr. T. J. McGillicuddy reports two cases of "Acute Puerperal Inversion of the uterus." One case died twenty-four hours after the accident, the other recovered. He is of the opinion that many cases of partial inversion or indentation at the fundus occur which rectify themselves, but which under favoring circumstances would have become cases of complete inversion.

The remaining papers in this issue are: "Subinvolution of the Uterus, and its Treatment by Electricity," by Dr. Charles G. Cannady; and a sketch of the life of Dr. Charles Jewett.

## PERISCOPE.

IN CHARGE OF WILLIAM H. BRICKER, M. D., B. SC.

## THERAPEUTICS.

**Chloroform as a Hæmostatic.**

As a general hæmostatic for controlling of external bleedings, arterial, venous, or capillary, chloroform is most valuable. Applied on a dossil of lint or cotton wool to the bleeding surface, it promptly stays the blood, acts as a direct stimulant to the patient, and leaves no blood crust to fall off and recommence the bleeding. It is peculiarly suitable for all abdominal operations, as it has no tendency to excite inflammation either in the part to which it is applied or to any of the surrounding tissues.

As an antiseptic application it is more powerful than bichloride of mercury solution. The addition of gum resins has been suggested, but they would detract from the value of the application instead of increasing it, for the reason which will occur to any person familiar with the use of solutions of gum resins.—*Medical Press.*

## MEDICINE.

**Congenital Absence of Right Kidney and Suprarenal Capsule.**

The following case may be worthy recording: A man, aged fifty-one, was admitted into the asylum suffering from melancholia. He was a fairly well developed man but rather poorly nourished. The skin of his face and body was of a dusky brown color, the pigmentation being deeper in the regions of the axillæ, penis and scrotum. The heart's action was weak, and he had a small, feeble pulse. He complained of a feeling of nausea and frequent vomiting and retching. A tentative diagnosis of probable Addison's disease was made, and he was placed under special observation. The patient committed suicide by strangulation on August 17th. At the *post-mortem* examination the ordinary signs of strangulation were found; but the point of interest was that there was an entire absence of the right kidney and suprarenal capsule. On dissection, no trace of the missing organ could be found, nor was there any vestige of a renal or suprarenal branch of the aorta or vena cava on that side. The right ureter also was entirely absent, and on opening the bladder only the left ureteral aperture could be found. The left kidney was quite healthy but of large size, weighing 9½ oz.—Ernest W. James, M. R. C. S., in *British Medical Jour.*

**Some Observations respecting the Pathology and Pathological Anatomy of Nodular Cystitis.**

Dr. Samuel Alexander, states that in certain cases of prolonged cystitis there have been observed, in addition to the usual changes due to chronic inflammation, a number of small nodules in the mucus mem-

brane of the bladder resembling the enlarged solitary lymph-follicles of the intestine. These nodules in the bladder vary in size from a small pin-head elevation to that of a large pea. Their number and situation likewise vary in different cases. Simular nodules have been observed in the posterior urethra, in the ureters, and in the renal pelves, but the study of these lymphoid formations in the urinary tract has excited very little interest, and it is still an open question whether the nodules observed in inflammatory conditions represent a normal part of the mucous membrane of the urinary tract, or to be regarded as new pathological formations. After a long and painstaking investigation, Professor Alexander has arrived at the following conclusions in regard to this condition:

1. That the lymphoid nodules which occur in certain cystitis represent a part of the normal mucous membrane of the bladder, and that the same is true in regard to nodular inflammations of the renal pelves, the ureters, and the posterior urethra.

2. That when there are a great number of lymphoid foci in the normal mucous membrane, infection of the bladder, if prolonged, is likely to assume a peculiar type, due to the enlargement of these foci into prominent and very vascular nodules, and that these cystitis should be regarded as a special clinical variety, to which the name nodular cystitis should be given.

3. That in cases of tubercular infection of the bladder, in which there are numerous lymphoid foci present in the normal bladder, these become enlarged, and as a result of the special infection undergo degenerative changes which are characteristic of tuberculosis.

4. That the lymphoid foci in the normal mucous membrane vary greatly in size and number, that prominent lymphoid nodules may occur in a bladder apparently normal, and without previous inflammation. This, however, is very exceptional, and it cannot be positively asserted whether the enlargement of the nodules in these cases is a normal or pathological condition.—*Jour. of Cutan. and Genito-Urinary Dis.*

**Post-Mortem Idrosis.**

A writer in the *International Medical Magazine* records the following curious phenomenon in a case of death from angina pectoris. "The face of the corpse seemed to be bathed in perspiration, the moisture reproducing itself after being wiped off, in spite of the presence of rigor mortis and other unmistakable evidences of death. This most extraordinary phenomenon was witnessed by several local physicians who also viewed the body. The funeral was on that account delayed several hours until decomposition had fully set in."



### The Chemistry of Fatigue.

According to Lagrange, the general effects following fatigue are due in part to the chemical changes which take place in the muscles as the result of physical exertion, and in part to the changes induced in the various organs in consequence of their increased functional activity of which exertion is the cause. The chemical changes which are produced in a muscle in activity consists in the formation of diverse abnormal chemical products, the residue, in fact, of excessive combustion, which always accompanies muscular contraction. There is present in a muscle, which is over fatigued, lactic acid, creatinine, uric acid, and these products gradually find their way into the blood, and so become generally disseminated. In the course of some hours they are eliminated by the urine as chemical analysis shows. While, however, these abnormal products are circulating in the blood they cause symptoms of a more or less toxic nature, such as a feeling of malaise, general lassitude, prostration, and sometimes even a rise of temperature.—*Med. Press and Circular*.

### Functional Diseases of the Alimentary Canal Accompanying Climatic or Temperature Changes—Etiology, Pathology and Clinical History.

Dr. F. W. Shaw in concluding his paper offers the following conclusions:

First as to etiology:

1. Any cause at any time of the year which creates in the intestines a condition of catarrh.
2. Fatigue or sudden chilling of the body.
3. High temperature and humidity.
4. Micro-organisms contained in air, water or food.
5. Any intestinal irritation or absorption of poisonous ptomaines.
6. Infection externally from decomposition of stools.
7. Active specific bacilli.
8. Age and individual powers of resistance.

Pathology:

1. Simple congestion of intestinal mucous surfaces.
2. Inflammation of stomach and intestinal mucous surfaces with loss of epithelium, and in severe cases loss of mucous and sub-mucous tissue with intestinal infiltration.
3. Ulceration with loss of substance.
4. Infiltration of solitary and mesenteric glands.
5. Formation of membranous coatings to intestine.
6. Grave constitutional symptoms with no marked pathological intestinal changes.

Clinical history:

1. Simple gastric or intestinal dyspepsia with nausea and vomiting with no constitutional symptoms.
2. Enteritis, gastro-enteritis, entero colitis and colitis with marked local and grave constitutional symptoms, approaching in the latter case those of collapse.

3. Sudden death within a few hours of attack, with no intestinal signs of pathological changes.

4. Diarrhoeas in all degrees of intensity, frequency, color, consistency and composition.

5. Vomiting, consisting either of mucous, undigested food or other stomach or intestinal materials, bile, blood or serum mixed with intestinal contents.

6. Specific action of certain pathological germs upon starches and sugars, resulting in an acid fermentation, and lastly, a similar action of other germs upon albuminoids, resulting in an alkaline fermentation.—*Brooklyn Med. Journal*.

### The Condition of the Urine in Relation to Anæsthesia.

Porter, of New York, writes in the July number of the *Post-Graduate* quite a long paper upon the subject, and concludes:

1. That ether and chloroform act upon the same principles, but with results developed by slightly different methods.

2. That both are capable of producing death at the time of the anæsthesia; chloroform more frequently than ether.

3. That ether causes as many, if not more, deaths than chloroform, but the fatal issue is delayed until the patient has recovered from the operating-table.

4. That by a careful study of the density of the urine and its causes we are in possession of exact information by which we can determine the nutritive condition of the system and are forewarned as to the possible outcome of the anæsthesia. It also enables us to judge which anæsthetic is best adapted to the individual case in question.

5. We are taught that neither ether nor chloroform should be administered until the glandular organs, in their necessarily damaged state, are put in the best possible condition to endure this extra strain. When this is a general rule many cases that now prove fatal will be saved.

6. It teaches that every public institution should have paid a physician who is competent to examine the urine and determine through it the status of the physiological economy before giving the anæsthetic. It should also be the duty of this same physician to administer the anæsthetic, for he alone knows best which anæsthetic to select with a given condition of the system, and is also better able to guide the patient safely through the anæsthesia than one who knows nothing of the constitution of the patient except from a second part.

7. While it is clear that death in some instances is directly due to the primary effects of the ether and chloroform, and in others to the secondary effects, it should not deter us from using them, but stimulate us to be more thoroughly master of their actions upon the system and to guard against their ill effects. When all this is accomplished, chloroform will probably hold the first place as an anæsthetic.



### Hernia of the Appendix—A Report of Forty-one Cases.

Dr. Brieger, of Breslau, has collected a series of 41 cases, 20 inguinal, 15 femoral, and 16 variety not stated. In 26 cases operation was performed; 16 cases were entirely cured, two were cured, but had a fistulous opening remaining, five died, and in three the result is not stated. From a study of these cases, Dr. Brieger comes to the following conclusions:

- (1) Hernia of appendix vermiformis is more frequent than is generally accepted.
- (2) It is impossible to diagnose with certainty a hernia of the appendix. Where there are present the symptoms of an incarcerated hernia in the right inguinal or femoral region, one should think of the possibility also of a hernia of the appendix.
- (3) A hernia of the appendix may produce more or less severe complications, inasmuch as the appendix is so frequently the seat of pathological process.
- (4) This form of hernia demands early operative interference, because of the threatened complications which may arise from the appendix.
- (5) This operation must, almost without exception, consist of resection of the appendix. The appendix must not be returned unless absolutely normal.—*Archiv. fur Klin. Chir., Ann. Surg.*

### Variola, Varioloid, and Varicella.

Biedert agrees with the conclusions of McCollom (*Boston Med. and Surg. Journ.*):

1. That varicella is often accompanied by considerable disturbance of the general economy.
2. That varicella is not necessarily a disease of childhood only, at least not of very early childhood. To which conclusions Biedert would add:
3. Varicella is sometimes to be distinguished only with difficulty from mild cases of varioloid or modified small pox in those who have been vaccinated. Under some circumstances it cannot be distinguished with certainty.
4. This has reference to the diagnosis only, and of course not to the real identity of the diseases.

Of variola he draws the following conclusions:

1. Up to the stage of eruption, variola is either not contagious or less so than later. Light varioloid is much less so than severe or very severe variola.
2. Many unvaccinated individuals show a lessened susceptibility; by others the susceptibility is so great that even one or two years after vaccination they are liable to the disease.
3. In the majority of individuals vaccination protects for seven years; in a larger or smaller number considerably longer.
4. Protection begins about eight days after successful vaccination. Vaccination after infection has already taken place does not protect; yet it is possible that the course of the disease is favorably modified, if the vaccination has been done at least seven days before the eruption.
5. Vaccination laws are insufficient in so far as they permit many children to remain for a long time unvaccinated, and thereby

become possible sources of an epidemic, as was the case in the present epidemic.

6. The more persons unprotected by vaccination and by revaccination, the greater is the danger in a community of an outbreak and of the spreading of an epidemic.

7. Isolation and disinfection are the more unsuccessful, in combating the disease, the more unvaccinated and improperly vaccinated persons there are in a neighborhood. An immediate vaccination of all such is necessary.

8. Energetic ventilation and the exposure of persons who come in contact with the patients to fresh air diminish the danger of contagion. Steam disinfection of the effects removes the danger from that source. Disinfection by sulphur alone may be sufficient.

9. In regard to treatment, these studies add nothing to what is already known.—*Archives of Pediatrics*, 1893 *Jahr. f. Kinderk. Leipzig*, 1892.

### SURGERY.

#### The Value of Stretching the Sphincter Ani in Chloroform Collapse.

In the long sad lists of deaths, says Dr. Alexander Duke (*Lancet*, London,) from chloroform in which the various means adopted for resuscitation (unfortunately ineffectual) are enumerated, I observe no mention of one of the most valuable, in my opinion, viz., *dilatation of the sphincter ani*.

This proceeding has been, I understand, in use in America for some time past, and is highly spoken of by Dr. Dally, in the *New York Medical Times*, February, 1893, as effective in cases of morphine poisoning.

I had lately an opportunity of putting to the test this plan of treatment in the case of a patient almost moribund after chloroform administration. The usual means having failed to obtain any response, I introduced my thumb into anus, and forcibly drew the sphincter towards coccyx. This had the immediate effect of rousing the patient sufficiently to gasp and cry out, and when repeated later on (as she showed signs of relapsing into the former condition), she so far recovered as to protest in a marked way against its repetition.

Dr. Dally's plan is to use a bivalve rectal speculum, and by its expansion to stretch the sphincter. As the speculum may not be always at hand, I think the finger (or thumb being stronger) will be found to effect the desired result.

Of course one case does not prove much, but by observation of its immediate effect in stimulating the respiratory functions, as stated in this paper, lead me to think it a most valuable and harmless proceeding.

The sphincter ani being the last portion of the body to give up its sensibility, the converse must be equally true, hence the importance, to my mind, of adopting this plan when the patient after an anæsthetic shows signs of collapse.

I trust that trial will be made of this American doctor's valuable suggestion, as I am convinced its importance is not known, and may be the means of saving life when the usual treatment has failed.

### Resections of the Kidney.

Kummel (*Arch. für Klin. Chir.*) publishes an interesting article on the subject of "Resections of the Kidney," in which, after referring to some experimental resections with regard to resections of the kidney in animals, he describes his own experience of three such operations in human subjects—noting similar operations already performed by Czerny in 1889, and by Waitz in the same year.

Of the writer's three patients, the first was a woman, aged forty-one, from whose right kidney he removed a stone of the size of a walnut. Finding a portion of the kidney practically destroyed by multiple abscesses, he removed that part of the organ. The wound made in the kidneys was only partially sutured—that part of it left open was sewed to the skin—and packed with iodoform gauze. The wounds healed completely, though slowly, and the patient made an excellent recovery.

The second case was a male, aged fifty-four. The chief symptom was pain and tenderness in the region of the right kidney, and hæmaturia. An incision was made parallel with the costal arch. On exposing the kidney there was seen at its upper end a yellowish area about the size of a walnut. This, together with a wedge-shaped section of the kidney, was excised. Sutures failed to control the hemorrhage. The kidney wound was thereupon fixed to the outer wound, and packed with gauze. The wound healed rapidly. The patient left the hospital at the end of three weeks, apparently well. Six weeks later he returned. A tumor of the bladder was then discovered. This was excised through a supra-pubic cystotomy. Rapid healing and recovery followed. The wound made in the bladder by the excision was sutured. Ten weeks after the last operation the patient died of pneumonia and empyema.

The third case was one of echinococcus of the kidney, in a woman of thirty-four. In this case the kidney was reached by a similar incision to that practiced in the two preceding cases. The kidney was greatly enlarged. Numerous echinococcus cysts were found, and freely incised. The cysts were then excised, together with portions of the kidney adjacent, by wedge-shaped incisions. The sutures failed to control the hemorrhage, as in the second case; and the kidney was, as in that instance, fixed to the outer wound and packed with iodoform gauze. About one-half the kidney was removed, the pelvis not being injured. This patient made a good recovery.—*Bost. Med. and Surg. Jour.*

Milton reports the "Extraction by Laparotomy from the Human Bladder of the Largest Stone ever recorded as successfully removed."

This stone weighed thirty-four and one-half ounces. The patient was an Egyptian, aged sixty. A mass extending to the umbilicus could be felt, and a sound passed into the bladder came at once upon a stone. An ab-

dominal incision was carried from the umbilicus to the pubes, exposing the anterior surface of the bladder. An attempt was made to strip the peritoneum from the anterior face of the bladder; but it failed. Thereupon the peritoneum was incised freely. The bladder was next incised, from its summit to its neck anteriorly—its peritoneal covering being, of course, divided. After making two lateral wounds in the course of the first bladder incision, the stone could be delivered by upward pressure exerted by two fingers in the rectum. The bladder wound was closed, except for a small opening at its lower part, with silkworm-gut sutures; the peritoneum with catgut, and the outer wound, except at its lower angle, with silver wire. There was no peritoneal reaction afterward; and the patient recovered from the operation, but died about two months later. The autopsy showed advanced disease of both kidneys. The largest diameter of the stone was six inches.

This case is especially interesting in view of the recent advocacy from various quarters, of opening the bladder through its serous surface as well as below, in order to get more room to work in, in certain difficult cases.—*London Lancet.*

Dittel has recently reported a case of total extirpation of the prostate, with recovery, in a man of thirty-two, who had been suffering from severe hæmaturia. A suprapubic cystotomy showed the source of the bleeding to be from a tumor (afterwards shown to be a fibroma) springing from the prostate. The growth was thought to be too large to allow of satisfactory removal through the suprapubic wound, and it was reached from below by an incision from the coccyx to the anus, separating the rectum from its attachments and then exposing the prostate by an oval incision. The urethra and bladder were not opened in this operation. Through this opening the prostate was wholly removed. The bladder was drained through the urethra, and the wound packed with iodoform gauze. The patient made a perfectly satisfactory recovery.—*Bost. Med. and Surg. Jour.*

### ARMY AND NAVY.

U. S. ARMY, FROM DECEMBER 17, 1893, TO DECEMBER 23, 1893.

Aydegger, J. A., Asst. Surgeon; granted leave of absence for fourteen days. To rejoin station, Pittsburgh, Pa., Dec. 7, 1893.

Stewart, W. J., Asst. Surg.; granted leave of absence for fourteen days, Nov. 27, 1893.

Strayer, Edgar, Asst. Surgeon, granted leave of absence for seven days, Nov. 27, 1893.

Oakley, J. H., Asst. Surgeon; to proceed to Halifax, Nova Scotia for temporary duty, Nov. 24, 1893. To proceed to New York, N. Y., for temporary duty Dec. 14, 1893. To proceed to San Francisco, Cal. for duty, Dec. 16, 1893.

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